Area Plan for Aging Services
PLANNING CYCLE
State Fiscal Years 2017-2020
SFY 2020
AREA PLAN

March 1, 2019

Item #1
SFY 2020 Area Plan Checklist & Area Plan Contents

(Indicate the applicable submission below.)

__x___ SFY 2020 AAA Area Plan Update Submission
_____ SFY 2020-____ Allocation Issuance (AI) Submission
_____ SFY 2020-____ AI AAA Initiated Budget Revision

	Place an "X" in the Column for "Yes", "No" or "N/A" below as applicable to the respective submission.			
***Denotes Signature Required**	**Yes**	**No**	**N/A**	**Comments**
Area Plan Narrative Checklist/Contents				
Item #2 - Letter of Intent*	x			
Item #3 - Executive Summary	x			
• #3a - Summary Description of Federal, State & Local Aging Network	x			
• #3b - Overview of the Area Agency on Aging	x			
• #3c - AAA Roles and Responsibilities	x			
• #3d - AAA Vision, Mission and Values	x			
• #3e - Purpose of Area Plan	x			
Item #4 – Context				
• #4a - Current and Future Older Persons	x			
• #4b - Needs Assessment Process and Results	x			
• #4c - Gap/Barriers/Needs to Improve Existing System	x			
• #4d - Special Needs	x			
Item #5 – Description of Service Delivery System	x			

Item #6 – Policy for Prioritizing Clients Most in Need	x			
Item #7 - Allocation, Budget and Units Plan				
• #7a - Allocations Methodology	x			
• #7b - Budget Narrative	x			
• #7c - Changes to Services/Units/Persons	x			
Item #8 – Agency's Indirect Cost Plan for SFY 2019* (Or the current Agency Indirect Cost Plan is included and it is noted **when** the SFY 2019 Agency Indirect Cost Plan is to be approved and available to the DAS.)	x			
Area Plan Attachments Checklist/Contents	**Yes**	**No**	**N/A**	**Comments**
Attachments A – Georgia State Plan AAA Designated ACL Goals and Objectives and Charts	x			
Attachments B - Location of Services Charts				
• Chart B #1 – Home and Community Based Services (HCBS)	x			
• Chart B #2 – Access Services	x			
• Chart B #3 – Community Care Services Program (CCSP)				**To be grayed-out by AAA. No update required.**
Attachments C - Compliance Documents				
• C-1.a – GA DHS DAS Request for Advance Payments Against Contracts Letter*	x			
• C-1.b - GA DHS DAS Request for Advance Letter	x			
• C-1.c - Request for Advance Worksheet	x			
• C-1.d - Letter of Bond Coverage*	x			

• C-2 - Standard Assurances*	x			
• C-3 – Letter(s) Requesting a Waiver of Standard Assurances is inserted* (Or it is noted on the C-3 Title page that no waiver(s) is/are requested.)	x			
• C-4 - Board Resolution*	x			
Attachments D - Required Plans (No Required Plans requested to be included in the SFY 2019 Area Plan Submittal.)	x			
Attachment E – Certification of Budget Submittal* (Indicate applicable Budget Submission)	**x**			
Attachment F - Title III OAA Federal Allocation and Match Analysis (Excel) (Indicate applicable Budget Submission)	x			
Attachment G - Area Plan Provider Site List	x			

Coastal Regional Commission of Georgia
Area Agency on Aging

1181 Coastal Drive, SW Darien, GA 31305

Serving the Cities and Counties of Coastal Georgia since 1964

March 1, 2019

Abby Cox, Director
Division of Aging Services
#2 Peachtree Street NW
Suite 9-100
Atlanta, GA 30303-3142

Dear Mrs. Cox:

The original Area Plan on Aging for the Planning Cycle of July 1, 2016 to June 30, 2020 is hereby submitted on behalf of the Coastal Regional Commission for the period of July 1, 2019 to June 30, 2020.

The Coastal Regional Commission Area Agency on Aging has the authority and responsibility to develop and administer the Area Plan in accordance with all requirements of the Older Americans Act (OAA), State of Georgia, and other federal and state programs as appropriate.

This plan reflects meeting all federal and state statutory and regulatory requirements and was approved by the Coastal Regional Commission Council at their meeting held February 13, 2019.

Sincerely,

AAA Director
Dionne Lovett

Executive Director
Allen Burns

Aging Advisory Council Chairperson
Farran Fullilove

Council Chairman
Reggie Loper

Items #3a through #3e – Executive Summary

Item #3a - Summary Description of Federal, State and Local Aging Network

The foundation of the Aging Network was formalized with the passage of the Older Americans Act of 1965. This legislation was instrumental in defining and creating the beginnings of what we now refer to as the Aging Network. This network has grown considerably through the years, but still includes core organizations such as the Administration on Aging, state Units on Aging, Area Agencies on Aging and service providers. The US Administration for Community Living or ACL (formerly Administration on Aging or AOA) is the federally designated agency that oversees nutrition, home and community based services for older adults and caregivers. ACL is a division of the US Health and Human Services agency. While ACL's main office is located in the DC area, there are regional offices throughout the United States covering the 10 regions. ACL works closely with each State Unit on Aging to provide vision, funding and regulations for the implementation and operation of aging programs throughout the state.

The GA Department of Human Services Division of Aging Services (DAS) is designated as the state unit on aging for Georgia. DAS works with Area Agencies on Aging (AAA), regional offices located in each of the 12 regional planning and service areas in GA. The Coastal Regional Commission (CRC) is the designated AAA for the nine-county Coastal Georgia region, offering services in Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Long, Liberty and McIntosh counties. The AAA serves all residents regardless of income, race or national origin. The AAA assesses, plans, and coordinates services and programs for senior adults, persons with disabilities, and caregivers of the region. The AAA works with local service providers to operate services at the city and county level. The aging provider network includes city and county governments, non- profit organizations as well as for profit businesses. In order to carry out the aging plan, the AAA works with many consumers, partners and community groups across the region.

The AAA has the responsibility for addressing present and future aging and long-term care issues within Coastal Georgia's growing and diverse communities. In 2015, the AAA contracted with Kerr & Downs Research to perform a needs assessment of local adults, 55 years of age and older and caregivers, to develop a demographic trend analysis to effectively estimate the demand for services and activities through the year 2035. Findings from the Census 2010 offer the most recent and comprehensive demographic and service-related data available in the region, providing a strong foundation for future planning and program development for our region's elderly and disabled residents.

This Area Plan reflects the goals, objectives, and activities of the Coastal AAA over the four-year planning cycle, 2017 through 2020. The Plan is consistent with the Older Americans Act (OAA) legislation and the guidelines set forth by the Georgia Department of Human Services Division of Aging Services (DAS). Most importantly, the Area Plan seeks to

inform the general public and regional policymakers of the development and delivery of services designed to foster independence and improve the quality of life for one of our region's most priceless resources – our senior adults.

Item #3b - Overview of the Area Agency on Aging

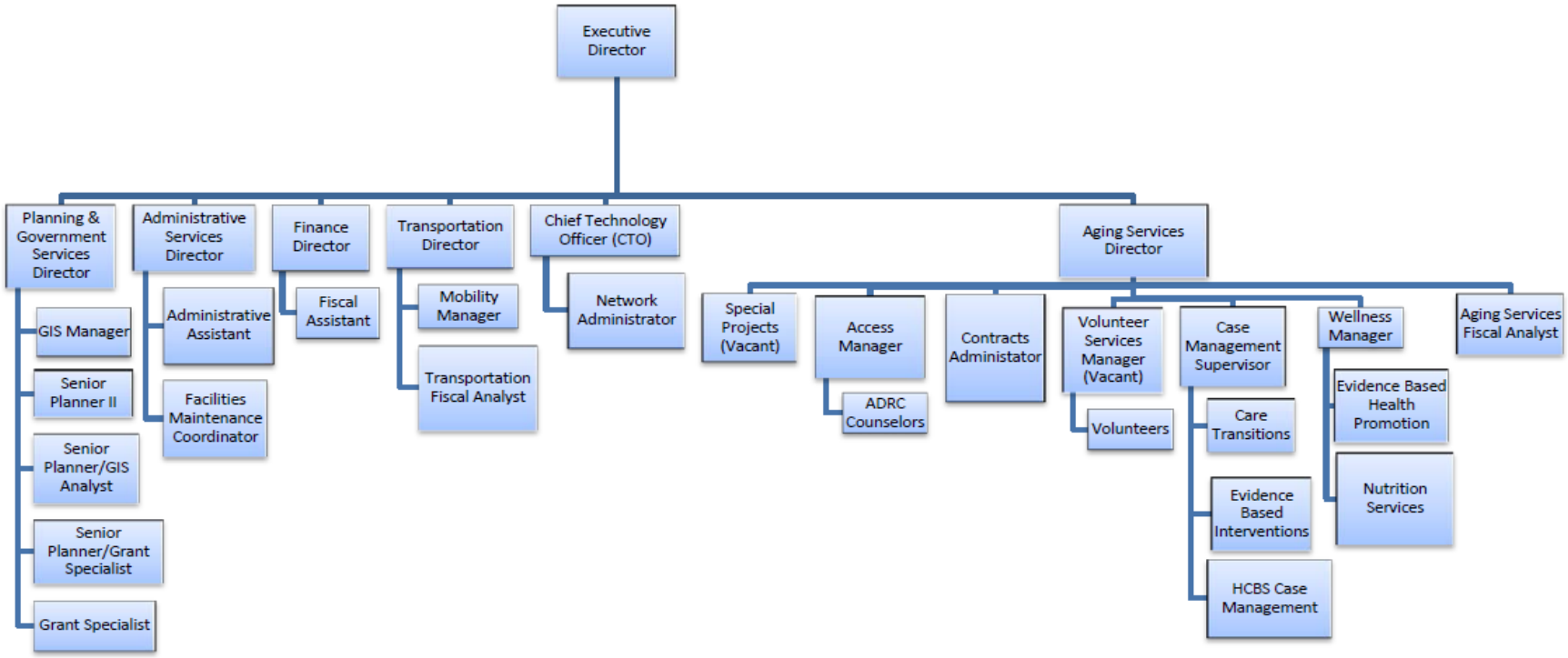
The Coastal Regional Commission (CRC) was formed in 1964, and has served as the Area Agency on Aging since 1973, providing nine counties and 30 cities with information and access to services for a growing and diverse aging population. Today, the CRC includes Screven County in its Planning and Service Area; however, for Aging programs, Screven continues to be served by the Central Savannah River Area Regional Commission.

The CRC Council serves as the governing body for the organization, and is comprised of thirty-nine (39) county, city, and at-large representatives from across the region. The CRC Executive Director reports directly to the Council and is responsible for the oversight and operations of the organization. In addition to the Aging Services, CRC supports four additional departments, including Administration, Finance, Transportation, and Economic Development/Planning & Government Services. Today, the CRC employs thirty-four (34) professionals and other contract staff.

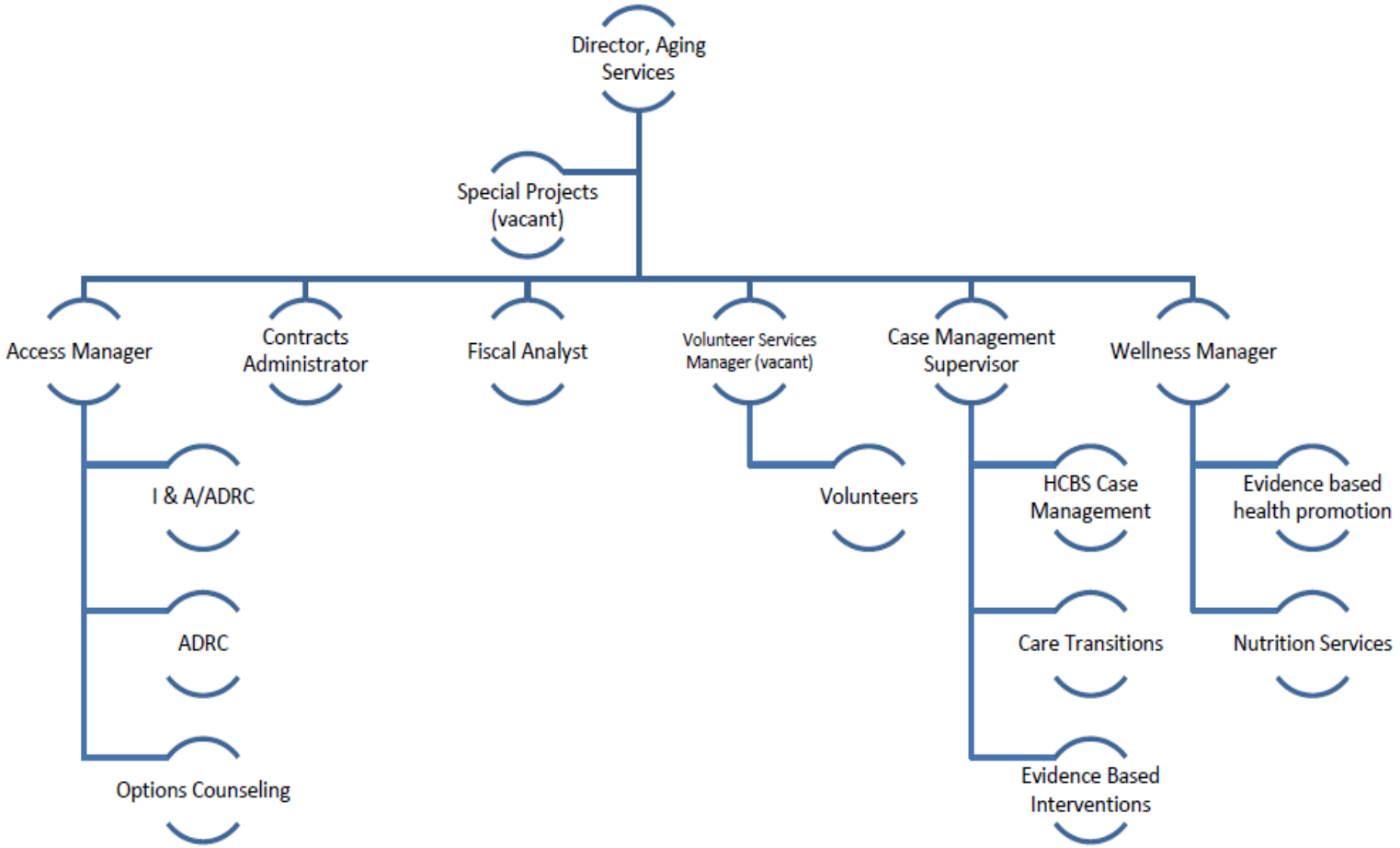
The Coastal AAA current staffing level is at 15 FTE's, and 3 independent consultants. The AAA sub-contracts with seventeen organizations to deliver information, programs, and services in a manner consistent with the vision, mission, and values of the organization, the Georgia Division of Aging Services, and the U.S. Administration for Community Living. The staff of the AAA consists of a director, 5 lead/management staff, 10.5 front line staff and a half time administrative assistant. There is currently one open position. In addition we leverage other community resources to expand our reach, having had three SCSEP enrollees as well as a two VISTA workers placed in our department within the last four years.

While it remains our desire to formalize our volunteer program by hiring a Volunteer Coordinator to provide oversight and management of volunteers for our agency and providers; funding limitations prevent us from doing so at this time. And all volunteers of our programs are recruited and managed by respective Program Managers throughout the agency. Our vision is to grow our pool of over 30 volunteers to 50 or more each year by providing engaging, meaningful assignments for those of all ages interested in volunteering their time and talents. CRC and AAA organizational charts are provided below:

Coastal Regional Commission Staff Organizational Chart



Area Agency on Aging Organizational Chart



Aging Services Advisory Council Members

Member	County	Past/Current Professional Experience
Vacant	Bryan	
Vacant	Bryan	
Vacant	Bryan	
Vacant	Bulloch	Higher Education / Business
Alice Holloway	Bulloch	Business
Mary Woods	Bulloch	Not Provided
Ceola Foreman	Camden	Not Provided
Farran Fullilove	Camden	Higher Education
Margaret Hudock	Camden	Not Provided
Margaret Kramer-Ellison	Chatham	Not Provided
Elizabeth Jones	Chatham	Not Provided
Howard Dawson	Chatham	Not Provided
Lucy Powell	Effingham	Healthcare
Linda Mercer	Effingham	Not Provided
Linda Wright	Effingham	Not Provided
Vacant	Glynn	Environmental and Economic Development
William France	Glynn	Government
Doris Carter	Glynn	Business
Henry Frasier	Liberty	Government / Clergy
David Anderson	Liberty	Government
Douglas Harn	Liberty	Government/Education
Vacant	Long	
Lillian Simmons	Long	Not Provided
Janet Watford	Long	Higher Education
Eunice Moore	McIntosh	Higher Education/Government
Lorraine Koenn	McIntosh	Mental Health
Olive Hillery	McIntosh	Not Provided
Daniel Brantley	City of Savannah	Higher Education / Gerontology
Dr. Doris Cope	City of Savannah	Healthcare

In accordance with the Older Americans Act legislation, the AAA has an Advisory Council made up of three representatives from each of nine counties (and two from the City of Savannah) in the region, the majority of who are over age 60. The Council meets quarterly to review AAA programs and to provide input regarding service and training needs in the region. The Council has an Executive Committee made up of a Chair, Co-Chair, and a Secretary, and operates under established by-laws. On official matters requiring action, the Advisory Council takes a vote and makes its recommendations to the CRC Council for approval.

There are a total of twenty-nine (29) positions on the Coastal Aging Advisory Council. As of this writing, there are eight vacancies to be filled. Of the 21 active Council members, 14 are female, 7 are male, and 11 are minorities. The vast majority of members are retired from a wide variety of professions. Two members are retired educators, four are former local government officials, some work-for-private businesses, and others manage programs in social service or housing organizations.

Item #3c- AAA Roles and Responsibilities

The AAA roles and responsibilities are outlined in the Older Americans Act of 1965. These responsibilities include both administrative roles and direct service roles. The administrative responsibilities include conducting a needs assessment of the planning and service area in regard to aging services, program development, coordinating a comprehensive network of services, contracting for the provision of services, training and technical assistance and evaluation. The direct service responsibilities include advocacy, outreach, Medicare insurance counseling, case management, information and referral and access, and volunteer management. The following chart outlines the roles and responsibilities of key staff within the AAA.

Title	Summary of Responsibilities
Aging Services Director	This position is responsible for planning, advocacy, coordination, monitoring and administration of the Area Plan and other resources available to the Area Agency on Aging. The Director maintains day-to-day operations of the agency with oversight for 50+ paid and volunteer staff. Ensures the effective coordination of aging services among a network of providers in the nine-county coastal region.

Aging Services Fiscal Analyst	Responsible for the accurate accounting of program funds and preparing financial reports for funding agencies and boards. Analyzes all financial information to know the status of program budgets and funds. Monitors and evaluates the performance of aging contractors and provides technical assistance as needed. Serves as the DAS Data System Security Administrator, providing access, monitoring and technical assistance to contractors on the use of the data base.
Aging Services Resource Specialist	Responsible for updating and maintaining the resource database according to the prescribed schedule. Keeps Aging Services staff informed of new resources in the region. Assists with compilation of resource guides. Conducts training in the use of the database. Provides outreach and community education as needed.
HCBS Care Manager (1)	Provides information, assistance, and expanded case management services to individuals who may not be appropriate for HCBS service or waitlist admission. The care manager may also broker temporary services using the Direct Purchase of Services (DPS) model. Also provides Care Transitions and Care Consultation interventions.
Access (ADRC) Manager	Responsible for the management and day-to-day operations of the AAA's ADRC Department, including direct oversight of the Options Counseling Program and MDSQ Options Counselor. Also oversees access to services for Caregivers and the Aging and Disabilities Resource Connection (ADRC). Provides oversight of Assistive Technology and Money Follows the Person Programs.
ADRC Counselor (6)	Responds to all inquiries regarding access to aging and disability services in the region. Conducts client assessments and gathers other information required to evaluate individual needs for services. Coordinates with other service providers to ensure effective access to care. Conducts follow-up with consumers to determine outcomes as needed. Provides outreach and community education as needed.
Wellness Manager	Responsible for monitoring contracted nutrition providers for compliance, coordination, and program development for the nine-county region. Provides technical assistance, nutrition education and counseling, conducts health promotion activities, Medication Management activities, health screenings, and outreach which promotes health and wellness for seniors. Also responsible for implementing evidence-based wellness initiatives throughout the regions congregate centers.
Contracts Administrator	Responsible for assisting the Aging Services Director with the oversight of regional human service programs. Other tasks involve working with local partners and service providers to coordinate the delivery of services. Manages contracts and projects as assigned; contributes to the sustainability of the department and its services through developing strategies, supplying relevant implementation documents, and grant preparation and administration. Responsible for monitoring aging service providers for regulatory compliance. Provides technical assistance to providers in program operations. Assists in preparation of provider contracts and budgets.

Case Management Supervisor	Provides oversight and management of all case managers and case management protocols and interventions. Responsible for brokering services using the Direct Purchase of Services (DPS) model. Also provides Care Transitions, RCI REACH, and Care Consultation interventions.
MDSQ Options Counselor	Responsible for utilizing a person-centered approach in providing options counseling services to individuals identified on the MDS assessment as wanting to speak with the AAA about community living options. MDSQ Options Counselor shall be supervised by the ADRC Program Manager or by another staff person who is supervised by the ADRC Program Manager.
Community Options Counselor	Responsible for utilizing a person-centered approach in providing options counseling services to individuals wanting to speak with the AAA about living options, service options and community resources. Community Options Counselor shall be supervised by the ADRC Program Manager or by another staff person who is supervised by the ADRC Program Manager. Coastal AAA has 8 staff that are certified Options Counselors.

Aging & Disability Resource Connection (ADRC)

In the role of providing information and access, the AAA serves as the regional Aging and Disability Resource Connection (ADRC). The goal of the service is to empower individuals to make informed choices and to streamline access to long term support including a wide range of in-home, community-based and institutional services and programs that are designed to help individuals with disabilities and chronic conditions. The vision is for the ADRC serving as highly visible and trusted place where people can turn for information on the full range of long term support options. The ADRC also serves as a single point of entry for both public and private-pay individuals to public long term support programs and benefits. The ADRC serves older adults, younger adults with disabilities and chronic conditions, family caregivers, as well as persons planning for future long term support needs. In addition, the ADRC is a resource for health and long term support professionals who provide services to the older adults and to people with disabilities.

The ADRC is supported by a strong technology-based infrastructure and a team-based approach for operations management. Trained professionals from multiple functional disciplines provide education, information, assessment, and customized referrals and connections to both private-pay and publicly-supported care options.

An Advisory Committee meeting quarterly provides input, feedback, connection to resources as well as provides outreach for the ADRC. The advisory committee consists of key stakeholders and is co-lead by our partner, Department of Behavioral Health and Development Disabilities (DBHDD). Our partner also is involved in program planning, outreach and decisions regarding the ADRC. In addition to assisting the AAA in the development of a comprehensive area plan, the advisory committee routinely receives reports on service gaps, customer satisfaction, call data and service requests and uses this data to drive their recommendations and input to the Coastal AAA leadership team.

Once a request for information or services is received; a trained intake specialist is the first contact for a customer. The intake specialist does an initial screening and assigns the referral to an ADRC Counselor depending upon the customer's county of origin. The ADRC Counselor then contacts the customer to complete the screening for services and/or provides the needed referrals. For customers desiring services, the Determination of Needs Revised (DON-R) assessment tool is completed to further assess the persons need. If the DON-R indicates a level of unmet need and services are available, referrals are made for services. Due to limited resources, everyone requesting services may not be assessed. In counties with a waiting list for services, a triage process is utilized to prioritize or determine which customers will be served and in what order. At this time, if eligible, the Community Care Services Program is explained to the customer. If there is a waiting list for services, the customer is placed on the waiting list, as well as given appropriate information. If the caller is a caregiver, ADRC Counselors also use the Bakas Caregiving Outcome Scale (BCOS) to determine if a referral to caregiving services is appropriate. Individuals on Tier I waiting list are screened every 6 months. Those on the Tier II waiting list are sent a letter requesting a rescreen after 12 months and removed from Tier II if there is no response to the letter.

Money Follows the Person Program (MFP) and Nursing Home Transitions are integral services within the ADRC. These programs are designed to help individuals who are in nursing or intermediate care homes, return to the community. The programs serve people with developmental or physical disabilities and those who are aging and who wish to transition back into the community. The programs can provide assistance such as security and utility deposits, furnishings and basic household items, moving costs, environmental modifications to make a home or apartment accessible, connection with peer supporters and other community resources, and other additional services. Each consumer wishing to leave the institutional setting is assigned a Transition Coordinator (TC) who provides guidance through the transition process. (All individuals under the age of 65 are referred to the local Center for Independent Living for TC services.)Each consumer must be screened to determine the level of support needed for a successful transition into the community. Monthly contact (by the TC) is maintained for a period of one year (365 days) in order to offer additional support as needed.

Options counseling, using a person-centered approach, offers individuals, families and caregivers information about community living services and supports. Options counseling explores public and private pay options with the consumer based on individual's identified needs, values and preferences. Options counseling is completed by the MDSQ Options Counselor (OC) who goes to the nursing home or intermediate home to complete face to face assessments with consumers. It is the role of the OC to help the individual to consider the pros and cons of his/her various service options in assisting the individual in making an informed decision. Long-term follow-up is a component of Options counseling that allows the OC to offer continued support and resources to the consumer following the face to face assessment. Options counseling is also provided through the ADRC to callers identified as needing assistance in exploring options related to long term supports and services. This counseling is provided by the Community Options Counselor to individuals not residing in a residential facility/ nursing home.

ADRC staff receives annual and ongoing trainings on topics such as Options Counseling, motivational interviewing, HIPAA, and many other topics to enhance services offered. In addition, ADRC staff is AIRS certified as well as several of the staff have earned a Certificate in Gerontology from Boston University School of Social Work.

The ADRC is responsible for outreach in the community to increase the general public's awareness of the ADRC and services offered. To achieve this, ADRC staff participate in community fairs throughout the nine counties on a monthly basis. To supplement these efforts, staff also provides trainings/presentations to discharge planners, social work departments and similar groups to promote the ADRC.

The ADRC continues to partner with GeorgiaTech, Tools 4 Life, Friends of Disabled Adults and Children (FODAC) and Living Independence for Everyone (LIFE) Center for Independent Living to enhance the interactive Assistive Technology Lab. Assistive Technology (AT) is an item or piece of equipment that is used to increase, maintain or improve the functional capabilities of individuals with disabilities in all aspects of life. AT ranges on a continuum from low tech to high tech. The AT lab is housed at the AAA in cooperation with GeorgiaTech. The lab is set up like a studio apartment; giving individuals the opportunity to actually put their hands on items designed to make everyday life more manageable or leisure time more fun. Items in the lab include those that assist people with mobility issues, dementia care, vision loss, communication problems, hearing loss and much more. ADRC Counselors encourage consumers to consider AT as optional resources. And the AT lab is open weekly for demonstrations and training. Coastal AAA contracts with the LIFE our local Center for Independent Living to provide one-one consultations one day a week our assistive technology lab.

Other Roles of the AAA

Coastal AAA is active in the communities we serve and strives to participate in activities and collaborations that keep us relevant at the local, state and national levels. The AAA works with other departments within the Regional Commission to always consider aging issues for integration in the regional planning process. For example in economic development activities, resources for older adults, caregivers and those with disabilities in our communities can be discussed with potential employers as a way to showcase what will be available to their future employees. In addition, attracting retirees to the area should be considered as part of the economic development strategy. For regional planning, the AAA plays a vital role in the link between planning and developing livable communities. Similarly, when assisting local governments with grant applications, the AAA assists by reviewing any grants pertaining to building senior centers, adult day care centers, assisted living facilities and similar projects. It is the AAA/ADRC's broad knowledge of the unmet needs and services requests of our target populations that make us a lead and key player in the development of a comprehensive service system. The AAA is using the call data collected through our ADRC on a regular basis to guide our decision making and service planning for Coastal seniors, individuals with disabilities, family caregivers and service provider agencies.

The AAA participates in many committees and advisory groups within the region including groups such as Healthy Glynn, Family Connections, healthcare alliances/associations, federally qualified health centers, and faith based organizations. Dionne Lovett serves on the College of Coastal Georgia Service-Learning Community Advisory Board, which serves to identify and create opportunities for students to practically apply and test their academic learning through hands-on experiences that also promote community interests. Ms. Lovett is the past president of the Georgia Association of Area Agencies on Aging (G4A), serves on the Georgia Gerontology Society (GGS) Board, and also serves on the eight-state membership Board of Southeastern Association of AAAs. AAA staff also actively participates on statewide boards and committees and are involved in projects through these groups. The organizations we work with promote the enhancement of the aging services network in our region and throughout the state.

Working Relationships with Community Organizations

To be successful, the AAA develops and maintains a variety of connections to a large array of community organizations. Many of our partnerships with agencies such as Adult Protective Services, Mental Health, public health and others are forged through participating on one of our many advisory groups. The AAA currently oversees or supports an advisory committee for the ADRC, Wellness, Coastal Georgia Caregiver Network (CARE-Net) and Elder Rights as well as our Aging Advisory Council and the CCSP Network meetings. These groups all have charters or purposes for existing and have attendees that are appropriate. We involve these agencies in tasks beyond those of advisory groups, such as our latest Request for Proposal review teams. We invited partners from DFCS, public health, Univ. of Ga Extension offices, banks, universities, other agencies etc. to participate in the reviews. The purpose was twofold; to help familiarize agencies with the work of the AAA as well as receive input from different perspectives.

The Elder Rights activities are supported by participating in a seniors and Law-Enforcement Together (SALT) council (Savannah region). Revitalization of the Coastal Alliance for the Protection of Elders, or CAPE, in the Brunswick area remains a focus of the AAA. Through participation in both of these organizations, the AAA focuses on the education around abuse, fraud and exploitation. The AAA supports both groups with staff time and funding. As a part of the Elder Rights work, the ADRC staff has a good working relationship with Adult Protective Services. They work closely with APS alerting through reporting when abuse, neglect or exploitation is suspected. The AAA has partnered with these groups to provide events such as the Shred-A-Thon, World Elder Abuse Awareness (WEAAD) Walkathon and educational conferences. Similar events will be planned through the next four year cycle.

The AAA, through an Abuse in Later Life grant made possible by the Criminal Justice Coordinating Council in Atlanta, partners with other local organizations in Chatham County to address elder abuse and create a Coordinated Community Response (CCR). Partner organizations include: the Rape Crisis Center of the Coastal Empire; the Office of the District Attorney, Eastern Judicial Circuit; and the Savannah-Chatham Metropolitan Police Department. The focus of this project is to provide additional training to agencies and organizations that serve elderly victims, including cross-training and in-

depth training for law enforcement; to formalize and strengthen a multi-disciplinary CCR; and to develop an outreach and services program for elder abuse victims in Chatham County.

The AAA views the older worker as a great source for our community because of the wisdom, skill, and work ethic they possess. Because of this value, the AAA provides training placement for older workers enrolled in the Senior Community Service Employment Program (SCSEP). In addition, the AAA has provided space and oversight for VISTA volunteers working on projects to help reduce poverty and increase volunteerism.

Item #3d - AAA's Vision, Mission and Values

The Area Agency on Aging reviews the mission, vision and value statements for the agency periodically and involves all levels of employees in this process. The CRC recently reviewed its own mission statements for the departments in order to develop one for CRC. The process allows employees to share their input on the vision of the AAA in order to update it and make it resonate with the customers we serve. Management uses staff input to update the AAA's mission, vision, and value statements. Our current mission, vision and values are relevant to the AAA responsibilities listed in the Older Americans Act (OAA) and mandated by DAS, as are our priorities.

Our Vision: All seniors, persons with disabilities, and family caregivers residing in Coastal Georgia will have access to information and services that promote physical health, mental well-being and options for living that ensure personal dignity and individual choice.

Our Mission: The mission of Georgia Area Agency on Aging is to foster the development of a comprehensive, coordinated system of services which promotes the independence and well-being of coastal area older adults and those with disabilities, and to provide these individuals and their caregivers with information and access to needed services.

Our agency policy and procedures include sound ethical standards and an antifraud policy. Employees are required to complete a Code of Conduct Questionnaire annually and all staff demonstrates conduct consistent with agency ethics and values.

Item #3e - Purpose of Area Plan

Under the Older Americans Act of 1965 as amended, the AAA is responsible for developing a regional plan for aging services to meet the needs of older adults, caregivers and those with disabilities. The purpose of the area plan is to provide a comprehensive and coordinated system of supportive services, nutrition services and senior centers, and the process used to determine the need for supportive services, nutrition services and senior centers within the planning & service area administered by the area agency. The plan describes how the area agency will implement, directly or through contractual or other arrangements, programs and services to meet identified needs within the region in accordance with the plan. Planning efforts and service delivery address the needs of older individuals with greatest economic need and older individuals with greatest social need, including low-income minority individuals, and individuals with limited English. In addition, through the development and implementation of the area plan, other agencies and organizations in the Coastal region can identify shared interests and work cooperatively to meet the needs of Coastal Region's older adults, caregivers and those with disabilities.

Items #4a through #4d – Context

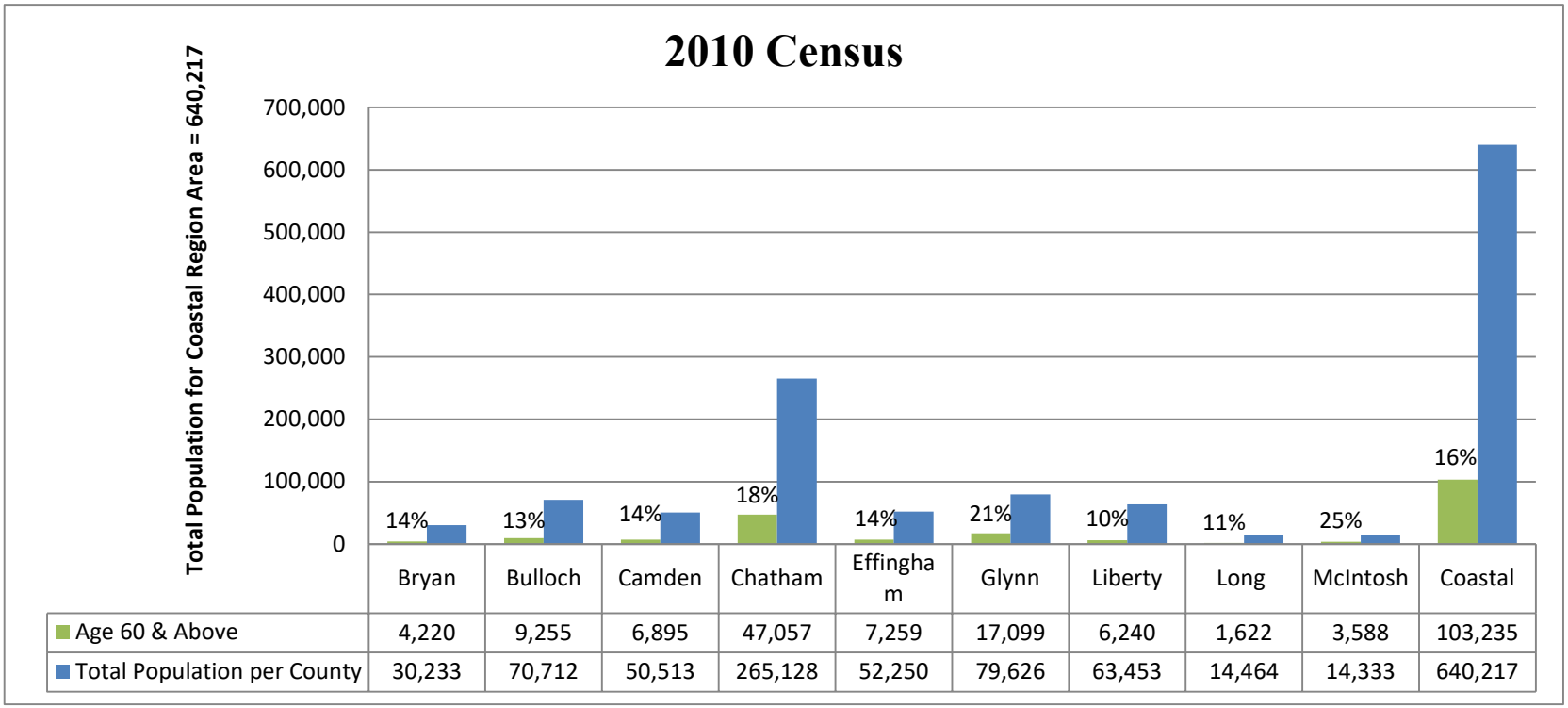
Item #4a - Current and Future Older Persons

The future needs of Coastal Georgia's elderly population will largely be driven by the rapid population changes that will occur over the next 30 years. The rising numbers of Baby Boomers reaching retirement age along with the growing in-migration to Georgia's coastal areas is expected to significantly impact services to seniors. In order to meet this paramount need, the Area Agency on Aging (AAA) remains committed to building lasting partnerships with organizations, private businesses, and local governments to ensure that our most frail and economically disadvantaged elders receive the care and services necessary to sustain healthy, independent, and dignified lives.

Population trends were analyzed using the US 2010 Census data, the State of Georgia Governor's Office of Planning and Budget Georgia Residential Population Projections by County: 2012 - 2030 report and the Georgia Coast 2030: Population Projections for the 10-County Coastal Region report. These documents provided valuable insight for planning for the increasing senior population of the Coastal region.

Growth in the Senior Population

The following graph reflects data taken from the 2010 Census. The total senior population for Coastal Georgia has reached 103,235. While the number of seniors age 60 and over are projected to increase in every county each year, there will be a shift in where they reside. It is projected that by the year 2030, Chatham County will be home to 42% of the seniors in the region, a drop of almost 10% from 2005. Over the same period, Bryan, Camden, and Effingham Counties will increase significantly in their percentage of coastal elders. The remaining counties will see little change over the next 25 years.



Item #4b - Needs Assessment Process and Results

Information from the 2015 Needs Assessment indicates that the percentage population growth in the service area varies considerably by age cohort as the figures below attest:

Age Cohort	2015-2035 Population Growth
55-59	35%
60-64	71%
65-69	56%
70-74	99%
75-79	107%
80-84	63%
80+	32%

Over the next 20 years, the 75 to 79 age cohort will experience the fastest population growth in percentage terms. The 80+ age cohort will experience the smallest population growth in percentage terms.

Percentage population growth is certainly one significant factor to consider when planning for the future needs of elders in the Coastal Georgia area. Another factor to consider is the absolute population figures. As the table below shows, the 55 to 59 age cohort was by far the largest (among elders) in 2015 at 44,568. By 2035, the 60 to 64 age cohort will be the largest (among residents) with 64,071.

	2015	2020	2025	2030	2035
55-59	44,568	48,477	52,387	56,297	60,207
60-64	37,527	44,166	50,801	57,436	64,071
65-69	30,728	34,988	39,248	43,508	47,768
70-74	22,125	27,602	33,082	38,562	44,042
75-79	14,641	18,570	22,495	26,420	30,345
80-84	9,715	11,242	12,762	14,282	15,802
85+	9,340	10,066	10,806	11,546	12,286

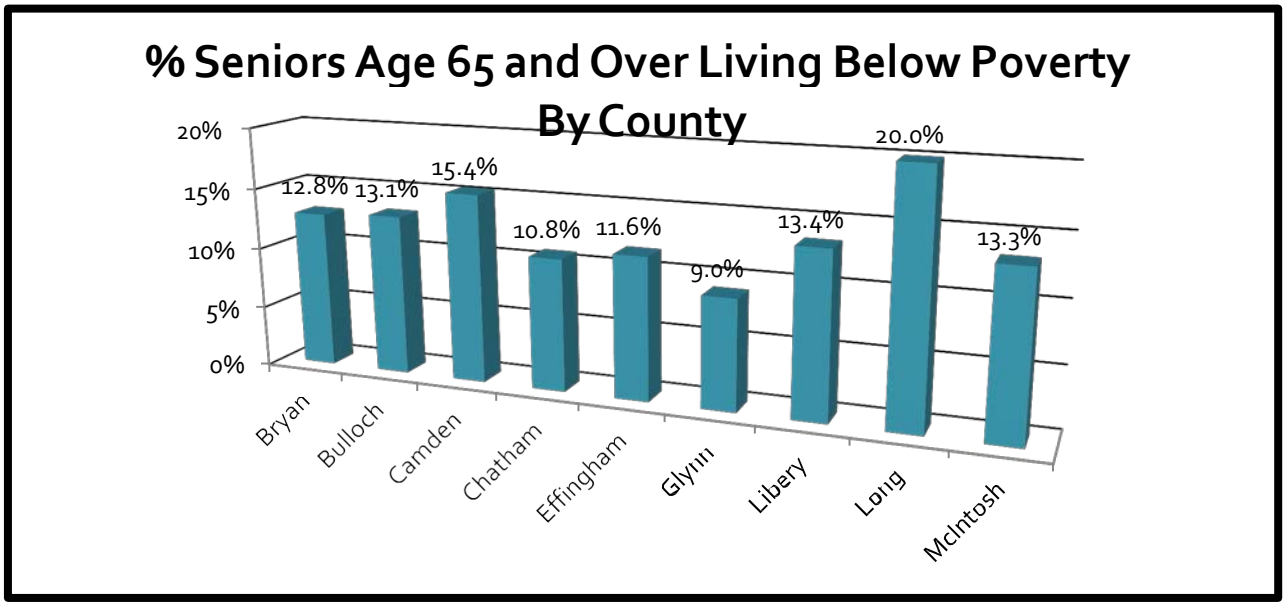
Poverty among Coastal Georgia Seniors

Aging in America brings concerns about economic security during old age. Although the poverty rate for the elderly is much lower today than thirty years ago, growing old and the cost of health care jeopardizes the economic security of the elderly. Specifically, the rising cost of long term health care has a great impact on the risk of the elderly being poor. According to the U.S. Census, the poverty rate for elderly women is substantially greater than the poverty rate of elderly men and the poverty rate of elderly blacks and Hispanics are more than twice the poverty rate of elderly whites in the United States.

According to Census 2010, approximately 13% of older adults in the coastal area are considered at or below the poverty level. In Long (20%), nearly 1 in 5 seniors aged 65 or older are at or below the federal poverty level. Those in the relatively urban counties of Chatham and Glynn fare best: in Chatham, only 10.8% of elders fall into that category, and in Glynn, 9.0% of elders are impoverished.

Not surprisingly, a much higher percentage of African- Americans than Caucasians aged 65 and over are poor. The disparity between the two races is particularly evident in Bulloch, Chatham, and Glynn Counties. There are 5.4%, 5.9%, and 6.5% differences, (respectively in these counties) where African-Americans show greater numbers of being below poverty as compared to Caucasians in the same county. McIntosh County is the only exception to this trend, where 15.9% of African-Americans are impoverished in contrast to 16.6% of Caucasians.

The table below provides the Census 2010 data for poverty rates in each of the nine Coastal Georgia counties.



Needs Assessment Process and Results

The needs assessment process began with identifying the information staff need in order to plan for a 4 year cycle. After this information was determined, the AAA contracted with a marketing and research firm (Kerr & Downs Research) to conduct a scientific telephonic survey of 1,000 55+ individuals in the coastal region. The firm worked with the AAA to finalize the questions which resulted in a 15-20 minute phone conversation. The study was conducted via random digit telephone interviewing during the months of May/June 2015. The sampling error for binomially distributed data given a 95% confidence level is 3.1 percentage points.

The purpose of the study was to: (a) catalogue the needs of individuals aged 55+ in ten counties within the CRC service area, and (b) conduct a "demographic trends analysis to document the numbers of 55+ year olds in the service area who will need specific services in the future. The study examined physical and mental health needs, personal and home related needs, nutritional and dietary needs, social and recreational needs and financial needs and self-sufficiency. Comparisons to a similar study conducted in 2010 are made throughout the report where appropriate. The 2015 study has a representative sample of all people who are over the age of 55 living in the coastal Georgia region (including Screven County). Results are reflective of the needs of all people 55 and older rather than only the needs of elders who are already accessing community resources through various agencies, organizations, churches and local government.

Of those surveyed, the average person living in Coastal Georgia was:

- 64 years of age
- Female
- Married/partner
- Living with at least one person
- Lived in area for 25 years
- White
- Total household income of just over $3,100 per month

The survey results were summarized in September 2015 and presented to various stakeholder groups such as the Aging Advisory Council, the Community Care Services networking group, and the CRC Council. The results were also discussed at Public Hearings held in October - December 2017. The results of the needs assessment along with customer satisfaction surveys and other feedback received during the year were used in determining and refining the needs of older adults, disabled adults and caregivers for the region. In addition, staff reviewed information on state and national trends in aging services to determine areas to target for future growth as well as trends to integrate into AAA operations.

Some of the recommendations included:

- Invest time in documenting and determining the regions aggregate capabilities to serve those who need services
- Identify gaps between capability to serve and needs
- Prioritize funding/resources needs
- Better publicize AAA efforts because 27% of the people surveyed do not know how well AAAs and other providers are doing in caring for 55+ year olds. And 41% do not know how well the community is helping people 5+ with loneliness and isolation
- 18% cannot afford key healthcare needs such as routine physicals, eye glasses, hearing aids, etc. – assess safety net organizations' resources
- 61% have a health issue; and 4% don't have a physician - need more programs to assist in self-care or dealing with chronic conditions as well initiatives to attract more physicians to the region to provide access to healthcare
- 15% have obstacles in maintaining good mental health (or 29,267 people by 2020) – Need to develop programs and partnerships to target this need. Perhaps inform mental health providers to encourage more pro bono work.
- 23% indicate they have emotional problems (or 44,876 people by 2020) – need to develop programs and partnerships to deal with these issues
- 33% say they will volunteer 5 hours a week which equates to 380,000 + volunteer hours per week – need to develop easy access for these people to "plug into the system" as well as provide good support and engaging opportunities. This significant resource of volunteerism can be used to provide solutions for the other needs.
- 26% say agencies, governments, healthcare providers, etc. are doing only a fair or poor job of fulfilling the healthcare needs – identify true inadequacies. And communicate healthcare capabilities more effectively.
- 21% have experienced house- related problems, such as caring for a house inside or out, trouble paying housing expenses or need of home modifications – need to form volunteer clearinghouse to match volunteers to those needing assistance
- 14% surveyed would like to receive assistance(transportation, errands, support group, homemaker, etc. of those, half are willing to pay for the assistance – Need to match volunteers up with those in need as well as consider developing more fee for service programs
- 47% want to participate in "sponsored activities" such as one would find at a senior center, community center or YWCA/YMCA. This equals 91,702 people by 2020. The sponsored activities need to be relevant, available and accessible – This finding indicates a need to review current senior center operations and determine a plan to increase relevancy to new generations of older adults.
- Of the caregivers surveyed, 50% were stressed 100% of the time – This finding indicates the need to expanded caregiver services and interventions.

- Of the 6% that placed a family member in an institution over the last year, 54% would have liked to talk to a trained professional before placement and over half would have paid for the service. This finding indicates the need for options counseling as well as further exploration of fee for service.

Item #4c - Gap/Barriers/Needs to Improve Existing System

Based on the 2015 Elder Needs Assessment and Demographic Trends Analysis, information gathered at public hearings, feedback gathered from client surveys, input from the Coastal Advisory Council and contracted providers, analysis of client records, call data and upon review of monthly AAA waiting list reports, there remain several serious gaps and barriers within the existing service system which prevent the AAA from achieving its vision for all seniors, those with disabilities, and caregivers of the region. In general, service gaps can be attributable to funding limitations, lack of available transportation, lack of resources, services and programs that met the needs of diverse families and older adults, and the need for increased education with outreach to access needed services.

As the demographic data indicated, the growth in the senior population will reach unprecedented proportions between now and the year 2035. The rising numbers of elderly coupled with the skyrocketing costs of healthcare in the U.S. significantly impacts the number of seniors on waiting lists for publicly-funded home and community based services. Coastal AAA has responded to this anticipated population growth and increased client need by pursuing grant dollars and forging new partnerships that help leverage limited local and state dollars and community resources to serve more clients and offer effective programs. As of January 2016, 1,718 older adults and family caregivers are waiting for services in the Coastal region, a 26% decrease from the 2,333 waiting in January 2014. However, this decrease is not indicative of being able to serve more people by providing them with HCBS services. Rather, it is a result of a more strategic approach to management of the waitlist. Working with the DAS, Coastal AAA has developed processes to prioritize which clients receive services. Based on this prioritization, if it is anticipated that a client may spend more than one year on the waitlist, other options are provided, and a waitlist placement is not made. While the AAA strives to make positive impacts on the waiting list, more than seventeen hundred individuals still wait for services, with more than 350 waiting for nutrition services. With the current limit on admissions to the CCSP Medicaid Waiver Program, that particular list has increased to 90 as of January 2016. More than ever, clients are recognizing CCSP as a more viable option than waiting on the ever-growing waiting list for Home and Community Based Services, despite cost shares and estate recovery associated with CCSP.

In the Demographic Trends Analysis conducted by Kerr & Downs (2015), more than a third of the Coastal residents (35%) indicated that it was difficult to find others to perform essential errands to secure food, medical assistance, etc. Transportation to medical appointments, church, pharmacy, grocery store, and other shopping areas remains an unmet need for most seniors and those with disabilities in this largely rural region. The vast majority of seniors and other consumers rely on family and friends to get them where they need to go. For many, there are few or no alternatives, and isolation can become problematic. At each public hearing and group gathering held this year, transportation was

consistently the number one service requested by seniors. *The Coastal AAA has identified at least 21 of its existing community partnerships that can aid in the growing need for transportation services. These partners include HCBS and Medicaid Waiver Service Providers, DFCS, and local county and city government.* Unfortunately, DHS Coordinated Transportation is overwhelmed with DHS consumers attending senior centers, with minimal dollars available to transport patients to dialysis or other medical appointments. While DHS Coordinated Transportation, through Coastal Regional Coaches, has added a much needed option for transportation throughout most of the region, the program has limitations and restrictions that lessen its impact on the need for transportation services to older adults. Coastal AAA continues to be an active member of the Region 12 RTCC, a collaborative of rural transportation service providers working to enhance transportation services in the Coastal region. The group meets quarterly and is committed to expanding transportation services. This fiscal year to further address the growing transportation disparity, Coastal AAA implemented a pilot project in Glynn County providing fixed-route transportation to and from Wal-Mart Super Center from eight senior-populated housing developments. The voucher transportation program will provide seniors transportation twice a month to a grocery outlet that includes home goods, pharmacy and vision (optometrist) services.

In the Demographic Trends Analysis conducted by Kerr & Downs (2015), significant healthcare needs among seniors in the region were identified. More than half of older adults (54%) in the Coastal Georgia region suffered from diabetes, hypertension, cancer, arthritis or some other on-going condition. Further, many of these older adults have difficulty accessing what they need to maintain their physical and mental health. Lack of money is noted as the key obstacle that keeps people in the Coastal Georgia region from accessing what they need to maintain their health. More than 1 in seven (14%) of Coastal seniors indicated they could not afford health insurance or medical prescriptions. This data suggest that significant numbers of Coastal seniors are at risk for increased chronic conditions and symptoms of mental illness due to gaps in healthcare.

Item #4d - Special Needs

Coastal AAA is increasingly working with more family members who are caring for loved ones with Special Needs. Many are under the age of 60 and are among the most vulnerable in the community. Outreach is done through professional organizations, health fairs, education seminars, mail outs, senior centers and the communities at large, in an effort to reach those in need of assistance to help them remain in their homes.

The ADRC provides information and assistance, referrals and resources to persons who request information about availability of services. Every effort is made to reach those living in rural areas to educate them about opportunities which might be available to them. Most recently, the ADRC, through it's AT lab initiative, provide tours and in-service workshops for educators of Special Needs children in the local school system.

Coastal AAA works closely with organizations that target minorities, individuals with low income and Limited English Proficiency, as well as persons at risk for institutional placement. Partnerships with local county health departments, clinics, hospitals, Departments of Family and Children Services, Adult Protective Services, Georgia Legal Services, Su Casa and other community social service agencies help us reach the most vulnerable citizens in the Coastal region.

The information systems used by our agency to house client data captures income levels, impairments, unmet needs, limited English proficiency, race and ethnicity. All this data is available to the ADRC staff when making referrals for service. This allows us to identify, prioritize and serve those with the greatest needs. The ADRC staff has been trained to assist LEP/SI persons both face to face and by telephone. Program information is printed in both Spanish and English.

Item #5 – Description of Service Delivery System

ADRC Information and Assistance Services

Coastal AAA's ADRC functions as a "No Wrong Door" access point to information, resources and services for older adults, individuals with disabilities and family caregivers of all social and economic levels, race and ethnicity. Coastal ADRC strives to provide individuals the information, assistance, awareness and access to services necessary to gain and/ or maintain their independence and to age in place.

Coastal ADRC traditional hours of operation are Monday through Friday, 7AM – 6PM. However, reasonable effort is always made to accommodate the needs of the caller. When necessary, screenings and client contacts are conducted outside of the ADRC traditional hours of operation. ADRC Specialist adjust their work schedules as needed to accommodate early morning, evening and even weekend assessments if necessary to complete the screening. Face-to-face assessments are provided by case managers and community options counselors when warranted. This flexibility in operating procedures allows Coastal ADRC to meet the needs of a growing and diverse population and maintain the established standards of promptness.

Community Transitions Services

Coastal AAA MFP Options Counseling Services provide individuals with information about community living services and supports to make informed choices about returning to the community. A person-centered approach is used to provide guidance that aligns with the individual's needs, preferences and values. The MFP Option Counselor conducts a face-to-face interview with the individual and helps with the development of an action plan. The program also provides assistance with connecting to services and periodic follow up.

MFP Transition Coordination Services are offered to all individuals residing in an institutional setting with a desire to transition into a community setting. Program participants are linked to home and community based log-term care options. The Coastal Transition Coordinator works with the individual to identify and eliminate barriers to transitioning to community living, build a support network and identify resources and services that will help the individual gain and maintain independence.

Nursing Home Transitions (NHT) Program provides individuals residing an institutional setting assistance with transition to a community setting/ living arrangement. To be eligible for NHT Services the individual must meet the income criteria for the program, have a minimum stay of (30) thirty consecutive days in a qualifying facility, and exhibit medium to high risk levels based on Risk Assessment Tool (RAT) scoring.

Community Care Services Program (CCSP)

The CCSP provides Medicaid-funded, community-based services to eligible functionally impaired individuals as an alternative to institutional placement, and is based on the premise that it is desirable to enable functionally impaired persons to reside at home or with their relatives or caregivers.

The goal of the CCSP includes supporting the following for people with functional impairments:

1. A continued ability to live in the community while receiving services
2. A continued choice in living arrangements and kinds of services received

This goal is achieved through the development of a system of community health and social services which provide a continuum of care for functionally impaired clients and assures that the least restrictive living arrangement is used to maintain independence and safety in the community.

Coastal AAA contracts with a regional service agency accustomed to delivering services in multiple counties, to provide care coordination in the Coastal region. The provider's responsibilities include brokering services, development of comprehensive service plans, monitoring service delivery to CCSP clients, monitoring service providers, client assessment, reassessment and discharge planning.

In SFY 2018, the Community Care Services Program will be provided under a contract with the Georgia Department of Community Health.

Elderly Legal Assistance Program (ELAP)

The ELAP provides persons age 60+ with legal representation, information and education in civil legal matters throughout the Coastal region. Program services include providing legal information and assistance, legal counseling, case representation and legal education session. The program focuses on helping older adults avoid more costly and time-consuming legal problems and combat exploitation. Priority is given to those with the greatest social and/or economic need, limited English speaking persons, those living in rural areas and low income minorities.

Coastal AAA contracts with Georgia Legal Services Program (GLSP) to provide services for ELAP. The provider has delivered legal services to older adults in the Coastal region for many years and is the current ELAP service provider for Coastal AAA. ELAP service delivery for FY2018 includes providing legal community education for at least 2,000 individuals and providing at least 2500 hours of legal and related counseling. Service activities will also include legal community education sessions at diverse venues throughout the Coastal region, targeting priority groups, older adults with the greatest social and/or economic need, persons with limited English proficiency, persons living in rural areas and low income minorities. A minimum of 350 clients will receive case representation through ELAP in FY2018.

GLSP will partner with the Coastal AAA to conduct outreach for ELAP and to target priority groups for service delivery. Further, this provider will assist with the development and implementation of an Elder Rights Plan for the Coastal region.

GeorgiaCares

Coastal' s GeorgiaCares Program is a volunteer-based program that provides free information and assistance to Medicare and Medicaid beneficiaries and their caregivers about Medicare, Medicaid and related health insurance issues including long-term care insurance, prescription drug assistance programs and Medicare fraud, error and abuse.

Coastal AAA is operating the GeorgiaCares Program under a waiver to provide limited services during FY2018 and will not continue operating the program in FY2019.

Home and Community Based Services (HCBS)

In-Home Services

Homemaker Services Program provides assistance to individuals unable to perform one or more of the following Instrumental Activities of Daily Living (IADLs): meal preparation, shopping for personal items/groceries, managing money/bill paying, using the telephone, light housework. Personal Care Assistance Program provides assistance to persons having difficulty with one or more of the following Activities of Daily Living (ADLs): eating, dressing, grooming, bathing, toileting, transferring in/out of bed/chair, or walking. Respite Care Services Program offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Some services are provided by individuals skilled in Alzheimer's care which offers temporary support for care recipients with Alzheimer's disease.

These services are provided in the home to persons 60 years of age or older, who are functionally impaired in their ability to perform regular activities of daily living. Services are designed to capitalize on the client's remaining strengths, lessen the burden of impairment, or to lessen the caregiver's burden. Coastal AAA relies primarily on three home health agencies to provide these services in the Coastal region: Altamaha Home Care, ResCare Home Care, and Nightingale Services. All three providers are licensed home health agencies with experience serving our target population. The providers' responsibilities include:

- Providing in-home service activities including but not limited to housekeeping and home management activities, meal preparation, escort assistance, chore/errand services, client education, assistance with personal grooming and health, and temporary substitute care.
- Conducting client assessments and reassessments.
- Conducting supervisory visits monitoring aide's performance.
- Developing, implementing and revising individualized service plans.
- Maintaining adequate staffing levels perform service activities

- Collaborating with the AAA, care coordination and case management staff on service delivery

According to ADRC call data, in-home services, both homemaker and personal care, are among the most frequently requested services by older adults and family caregivers. While these services are highly requested, there are seldom service slots available, as these services are costly and the older adults need for hours of service generally increase over time. While waiting lists for in-home services continue to grow, funding has remained fairly stagnant. In an effort to address this service gap, Coastal AAA is working to match callers with and provide assistive devices that can help meet some housekeeping and personal care needs, i.e. robot vacuums, Reachers, bathtub grab bars, no rinse soap, bath brushes, emergency response systems, etc.

Home and Community Based Services (HCBS)
Nutrition and Wellness Programs

Congregate Meals

Congregate Meals is defined as a meal provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and State/Local laws.

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C1, and Administration on Aging (ACL), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture (USDA) and local funds.

Providers of Congregate Nutrition services in the coastal region for fiscal year 2017-2020 are:

- Concerted Services, Inc.
- Senior Citizens, Inc.
- Camden County Board of Commissioners
- City of Savannah
- Bryan County Board of Commissioners
- Effingham County Board of Commissioners
- City of Brunswick
- Long County Board of Commissioners
- McIntosh County Board of Commissioners

All of the Congregate Nutrition Service Providers are operating traditional senior center models. The centers offer at least three or four hours of planned activities daily and each provider is receiving ongoing training and technical assistance on developing and implementing “client-choice” menu options.

Home Delivered Meals

Home Delivered Meals is defined as a meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act and State/Local laws.

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C2, Administration on Aging (ACL), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture (USDA), and local funds.

Providers of HDM Nutrition services in the coastal region for fiscal year 2017-2020 are:

- Concerted Services, Inc.
- Senior Citizens, Inc.
- ~~Bryan County Board of Commissioners~~
- Effingham County Senior Center
- Heavenly Devine Blessings
- Mom's Meals
- Long County Board of Commissioners

Nutrition Education

Nutrition Education is defined as a program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers or participants and caregivers in group or individual setting overseen by a dietitian or individual of comparable expertise.
In addition to the meal service provision, each contractor is responsible for coordinating and providing nutrition education sessions, conducting nutrition screening activities, and making referrals for nutrition counseling.

The AAA provides regular Nutrition and Quality Assurance Training for center managers and food service staff to ensure a comprehensive meal service program. Coastal AAA offers other services which maintain health; this includes Health Promotion and Disease Prevention, Medication Management, Exercise/Physical Fitness, and Recreation activities. These are provided through contract requirements.

Home and Community Based Services (HCBS)

Case Management - Care Transitions

Case management is a service designed to provide consumers access to community resources and provide on- going coordination of services and monitoring of the client's well-being. Case management services shall include, but are not limited to, the following activities:

- Assessment for, planning and implementation of service options,
- Development of individualized service plans
- Brokering of HCBS in-home services
- On-going coordination and monitoring of services
- Client linkage to available community resources that promote health, quality of life and positive outcomes
- Education about disease processes, lifestyles choices (diet, exercise, medication compliance, etc.) and preventive measures that prolong life and promote healthy living.

Coastal offers short-term HCBS Case Management program through our Care Transitions Program in Camden, Glynn and McIntosh Counties. The program aligns with the Model for Access to Services and Case Management proposed by the Division of Aging Services during FY2015 as a part of Case Management Redesign. The Care Transitions Program is predicated on the evidence-based Bridge Model developed by the Illinois Transitional Care Consortium. It is designed to reduce the number of hospital readmissions by providing high-risk older adults with care coordination for 30 days after discharge. The goals for the program include:

- Reduce hospital readmissions within 30 days after discharge,
- Promote effective and safe patient transitions,
- Increase patient ownership through physician follow- up and understanding of prescribed medication/treatment,
- Reduce the level of unmet needs through coaching and problem-solving,
- Increase patient knowledge of their disease process, and
- Improve collaboration between community agencies.

The Coastal AAA is partnering with the Southeast Georgia Health Systems to offer transition supports to patients. The focus is on vulnerable older patients with Renal Failure, Congestive Heart Failure, Pneumonia, or Acute Myocardial Infarction.

Coastal AAA has advanced its Care Transitions Program to a fee-for-services model. The AAA Director successfully negotiated a contract with the hospital system serving Camden, Glynn, and McIntosh Counties to pay a flat rate for all patients enrolled in the Care Transitions Program. Plans for FY2017 include expansion of the Care Transitions Program to additional hospital systems and counties, as well as exploring more opportunities to implement fee-for-service models with our other evidence based programs. Care Transitions is available in Camden, Glynn and McIntosh Counties.

Coastal AAA is partnering with Aging & In-home Services of Northeast Indiana, Inc. to provide care transition and case management services to high-risk or vulnerable customers of Anthem Health Insurance. The partnership was developed

stemming from introductions initiated by N4A leadership in support of AAA efforts towards building sustainable fee for services programs and establishing community partners in both the public and private sectors that could aide in the formation of an all-encompassing service delivery system for older adults and individuals with disabilities. Coastal AAA is hoping to give patients increased opportunities to learn about their chronic diseases and measures to improve their health while the patient is in the hospital and when they return home.

HCBS Case Management

While Coastal AAA has traditionally provided case management services to family caregivers and individuals transitioning from a hospital setting, during the 2017-2020 planning cycle Coastal AAA will expand case management services in the Coastal region to provide supports to clients identified through a comprehensive assessment process as most appropriate for case management. Due to limited resources, enrollment in the program will be restricted to those clients identified as "clients of greatest need" and clients with the ability to private pay for services. While enrollment will be restricted to those in greatest need, the service will be available in all nine counties.

Case Management Services are reserved for complex cases. Clients are referred to case management if identified as "at risk" of institutional placement, homelessness, harm to self (neglect), transitioning between care settings and/or at risk of losing primary resources or caregiver supports.

Coastal AAA is utilizing the state's guidelines and review guide for Case Management Services to evaluate the program on an annual basis. Coastal uses feedback and guidance provided by DAS during monitoring visits, monthly calls, and quarterly meetings/trainings to continuously evaluate the program.

Care Consultation

Coastal AAA provides telephonic coaching and support services via a non-volunteer model using a protocol developed by the Benjamin Rose Institute on Aging and adopted by the Rosalyn Carter Institute for Caregiving as the "Care Consultation" program. Care Consultation Services are provided to persons age 60 or over and to persons, regardless of age, caring for someone with Alzheimer's disease or a related disorder. The services are also available to clients with the ability to private pay for services.

The program helps educate clients about community resources and strategies for caregiving while providing emotional support and decreasing isolation.

Telephone Reassurance

Coastal AAA Telephone Reassurance Program provides Interaction with individuals by telephone to reduce social isolation, provide support and ensure health and safety. This service is provided to clients receiving home-delivered meals in Glynn and McIntosh Counties.

Adult Day Care & Mobile Adult Day Care

The Adult Day Care Program provides personal care for dependent elders in a supervised, protective, congregate setting for at least six (6) consecutive hours each day, Monday-Friday. Services offered typically include social and recreational activities, training, counseling, meals, medications assistance, and personal care assistance.

The Mobile Adult Day Care (MADC) Program is provided by agency staff that is capable of traveling from one location to another on a daily basis, to various sites, primarily in rural locations, so as to provide care in areas that are underserved. MADC services are typically provided in one or more locations in any given week, generally in a community setting, such as a church or public facility where accommodations for services can be met.

Coastal AAA contracts with the City of Savannah, Senior Citizens Inc., and the City of Brunswick to operate three ADC programs, two in Chatham County and one in Glynn County. Coastal AAA also contracts with Senior Citizens Inc. to operate a MADC program in Liberty County offering ADC services three (3) days each week.

ADC and MADC service providers operate these programs utilizing a social model and/or medical model of service delivery and serve qualified individuals, age 60 and older who are experiencing some degree of impairment in their physical and/or cognitive functioning and to individuals under the age of 60 with a diagnoses of Alzheimer's or related dementia.

Alzheimer's Programs

Coastal AAA has implemented the Georgia REACH program, an intervention for caregivers of individuals with Alzheimer's disease, dementia or related disorders, as we seek to:

- Learn as much as possible about the experiences of families with Alzheimer's or related dementia in this region, and
- Link families to the resources/programs that are most appropriate to meet their needs.

The goal of the program is to reduce caregiver burden and improve or sustain caregiver physical and emotional health. This is accomplished by identifying the areas that the caregiver feels are their most challenging or where they need help. Each session is tailored to address those areas. Coaching the caregiver in problem solving skills and how to access information and resources will empower them to continue to cope with their challenges even after the program is ended.

Coastal AAA contracts with three (3) independent consultants to provide the REACH Intervention throughout the Coastal region. To date, more than 100 family caregivers have successfully completed this intervention. And with an expansion

grant from Roslyn Carter Institute, Coastal continues a targeted effort in Chatham county; focusing on minority families in the urban areas of Savannah.

Community Education: Evidence-Based Programs

Evidenced-Based Programs (EBPs) are specific protocols and interventions that have been researched and proven to produce positive outcomes, which can be used to promote good health among older adults. Some of the benefits of participating in evidenced based programs for older adults include improved quality of life, increased independence, positive health behaviors and reduced pain. The benefits to community based organizations that provide EBP's include more efficient use of resources, increased community collaborations and improved health outcomes for our clientele.

Chronic Disease Self-Management Education (CDSME).

CDSME provides opportunity to inform the community as well as local community partners on evidence-based programs offered through the Coastal AAA. The Wellness Program Manager, ~~Wellness Ambassadors~~, Master Trainers, and volunteer Lay Leaders generally provide program presentations. These individuals also facilitate group workshops.

Chronic Disease Self-Management Program (CDSMP)

CDSMP is based on Albert Bandura's Theory of Self-Efficacy and helps participants develop coping skills and strategies they need to manage their symptoms through action planning, interactive learning, behavior modeling, problem solving, decision-making, and social support for change. Dr. Kate Lorig and her colleagues at Stanford University's Patient Education Research Center created this program. The CDSMP/*Living Well Coastal* is a self-management program, which empowers people to take an active role in managing their chronic illnesses. Facilitated sessions cover 17 different topics over a six week period. Older adults, caregivers, and people with disabilities will be targeted who suffer from any chronic condition.

Topics to be facilitated include pain management, healthy eating, exercising, use of medication management, emotional management, build communication skills with doctors and clinicians, and introduction to other helpful self-management tools. CDSMP is offered throughout the entire coastal region. Over, the next four years, development of partnership and collaboration with local and community agencies, churches and faith-based groups, civic groups, and hospitals, will be targeted to help sustain the CDSMP Living Well Coastal Program.

A Matter of Balance (MOB): Managing Concerns about Falls

MOB is a fall prevention program for people who may have limited daily activities due to a fear of falling and may have limited their daily activities. The MOB model was developed by the Roybal Center for Enhancement of Late-Life Function at Boston University. MOB is designed to address concerns about falls in group settings for older adults. This program addresses the risk of falling, but also includes coping strategies to reduce the concerns of the fear of falling. The eight-

week workshop is facilitated by trained facilitators for groups of 10-12 people. Participants learn to control the fear of falling, set realistic goals for increased physical activity, find ways to change the environment to reduce fall risk factors, and learn simple exercises to increase strength and balance.

Powerful Tools for Caregivers (PTC)
PTC is a nationwide evidence-based program for caregivers. This program was developed by Legacy Caregiver Services in Portland, Oregon. The class is offered one day a week for six weeks to family caregivers. The class provides a wealth of information including self-care tools to reduce personal stress, change negative self-talk, communicate the needs to family members and health care providers, dealing with difficult feelings and emotions, and making tough caregiving decisions.

Tai Chi for Health
Tai Chi for Health is a gentle exercise. The Tai Chi for Health series is based the teaching of Dr. Paul Lam, Tai Chi gold medalist. Tai Chi has been endorsed by the American Arthritis Foundation, Centers for Disease Control for Fall Prevention, by the MS and Parkinson Foundation. The Coastal AAA Tai Chi for Health Arthritis and Fall Prevention program focus on fitness, balance, and strength. The program gets people moving, improves mobility, and help prevents falls.

Over, the next year, development of partnerships and collaborations with local and community agencies, churches, faith-based groups, and civic groups, will be targeted to sustain the evidence-based programs. The Coastal AAA Master Trainers will continue to train lay-leaders in our communities to continue and sustain the expansion of evidence-based programs throughout the Coastal region. The active lay-leaders will assist by offering workshops in the community.

~~Long-Term Care Ombudsman Program~~
~~The Office of the State Long-Term Care Ombudsman contracts directly with providers of Ombudsman Representative services with federal funds appropriated to the Act for that purpose. The AAA relies upon the Office of the State Long-Term Care Ombudsman and the State Agency to assure that funds are expended appropriately in compliance with the Act. The AAA remains in contact with the Ombudsman Representative agencies for purposes of making referrals to the Ombudsman Representatives and for the Ombudsman Representatives to make appropriate referrals to the AAA for ADRC, SHIP and other aging programs that may assist long-term care facility residents. Ombudsman Representative agencies are required to participate with the AAAs in community outreach and education, issues advocacy, and interagency coordination activities when possible."~~

Item #6 – Policy for Prioritizing Clients Most in Need

Coastal AAA has adopted *Policy 118 Prioritizing Clients* of the HCBS Operational Manual. The Coastal ADRC Program Manager is tightening internal processes for maintaining our waiting list for services. Due to limited resources, everyone requesting services may not be assessed. In counties with a waiting list for services, the DAS triage process is utilized to prioritize or determine which customers will be served and in what order. Streamlining the rescreen process and increasing utilization of Options Counseling for clients waiting for services. Via quarterly desk reviews and regular provider trainings, our service providers are receiving technical assistance on client prioritization, sustainability, cost share and service utilization.

Individuals calling the ADRC requesting services that do not have needs that are going unmet most of the time will not be placed on the Tier 1 HCBS waiting list for services. Other avenues for obtaining assistance with care are discussed with these individuals. Said clients may be placed on Tier 2 waiting list for services. This process reduces the risk of placing individuals on a waiting list for services that are not likely to be served. Individuals on Tier I waiting list are screened every 6 months. Those on the Tier II waiting list are sent a letter requesting a rescreen after 12 months and removed from Tier II if there is no response to the letter.

Items #7a through #7c – Allocation, Budget and Units Plan

Item #7a - Allocation Methodology

The Coastal AAA uses the intrastate funding formula to formulate a basis for allocating the funds throughout the region. A great deal of care and consideration are taken to ensure that current clients will continue to receive services as well as redistributing funds from counties that have excess funding to those that have a significant amount of people on their waiting lists. The primary goals are to ensure that funds are utilized according to federal and state guidelines, and that they are allocated in an equitable manner.

Item #7b - Budget Narrative

In SFY2020 there is a reduction in CBS one-time funding in the amount of $35,058. The reduction is taken in AAA administration to minimize the effects of the reduction on any individual provider or service. The only other reduction is the termination of SSBG Special Projects funding of $11,200.

Item #7c - Changes to Services/Units/Persons

Coastal continues to work with providers to secure other funding sources to ensure service delivery in all counties. Coastal will monitor provider budgets and units to safeguard client services for SFY 2020.

Coastal Regional Commission

1181 Coastal Drive SW
Darien, GA 31305

Tel: (912) 437-0800
Website: http://www.crc.ga.gov

Cost Allocation Plan

For the period July 1, 2018 – June 30, 2019

Contact Person(s):

Executive Director: Allen Burns Email: aburns@crc.ga.gov

Finance Director: Lena Geiger Email: lgeiger@crc.ga.gov

INTRODUCTION

The Coastal Regional Commission (CRC) is a local governmental entity established through the enactment of the Georgia State Planning Act of 1989. The Official Code of Georgia Annotated (OCGA) Section 50-8-31 et el, is the basis of the Coastal Regional Commission's existence. Membership in the Commission consists of each municipality and county in Region 12 of the state of Georgia. The territorial boundaries for Region 12 are as follows: Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh, and Screven counties.

The Coastal Regional Commission is an organization constituted to serve its members and shall be member driven. The purpose of the Commission is to create, promote, and foster the orderly growth, economic prosperity, and continuing development of the industrial, civic, commercial, educational, natural, and human resources of the Region and member communities. The Commission functions as the regional planning entity for land use, economic development, environmental, transportation, historic preservation planning, coordinated transportation, and services for the elderly, persons with disabilities, and their caregivers.

A. COST ALLOCATION METHODOLOGY

This cost allocation plan (the plan) is to establish an indirect cost rate for the period of July 1, 2018 – June 30, 2019, the CRC's fiscal year

The plan addresses all elements of cost incurred by the CRC and identifies shared costs that require allocation. The CRC treats all costs as direct costs that can be specifically identified with a project. General administration and other allowable costs that are incurred for the common good of the organization are treated as indirect costs and are pooled and distributed to benefiting projects by a cost allocation process.

B. DIRECT COSTS

Direct costs are costs that can be identified with a specific project and therefore charged to that project. The accounting system records these costs as they are incurred within the series of accounts assigned for that purpose. The CRC maintains adequate internal controls to insure that no cost is charged both directly and indirectly to Federal contract or grants.

C. INDIRECT COSTS

Indirect costs are costs incurred for common or joint objectives and therefore cannot be readily and specifically identified with a particular project or activity. These costs are grouped into common pools and distributed to benefiting projects/activities by a cost allocation process.

D. COST POOLS AND BASE FOR DISTRIBUTION

Fringe Benefit Cost Pool

The CRC has established a Fringe Benefit Cost Pool consisting of paid time off, payroll taxes (FICA), pension costs, health, dental, vision, life and worker's compensation insurances, as well as an estimate for unemployment benefits. A fringe benefit rate is calculated based on the ratio of total fringe costs to total chargeable salaries. Fringe costs are allocated to specific projects using this rate times the chargeable salaries for a specific project.

Total fringe benefit costs	(A)	$838,707	Total chargeable salaries
	(B)	$1,677,805	
Fringe Benefit Rate = (A) / (B)		49.99 %	

Indirect Cost Pool

The CRC has established an Indirect Cost Pool consisting of salaries, allocable fringe benefits, and other indirect costs. The Indirect Cost Pool is charged with all of the indirect costs as defined above. An indirect rate is calculated based on the ratio of total indirect costs to the portion of chargeable salaries, plus fringe benefits not charged to the indirect cost pool. The pool is distributed to various program activities using this rate times the sum of chargeable salaries plus allocable fringe benefits for a particular project/program.

Total indirect costs	(A)	$1,144,257	Chargeable salaries
plus fringe (B)	$1,802,010		
Indirect Cost Rate = (A) / (B)		63.50 %	

E. UNALLOWABLE COSTS

The CRC recognizes that unallowable costs, as defined by 2 CFR Part 200, cannot be charged to Federal awards and has internal controls in place to insure that this is followed. If the CRC incurs any costs that are deemed to be unallowable to Federal awards, those costs are charged to the general fund and not to any Federal or State award or any cost pool.

F. DESCRIPTION OF ACCOUNTING SYSTEM

The CRC uses the current financial resources measurement focus and the modified accrual basis of accounting. Under this method, revenues are recognized when measurable and available. The CRC considers all revenues reported in the governmental funds to be available if the revenues are collected within twelve (12) months after year-end. Dues from member county and municipal governments and the earned portion of grants and contracts are considered to be susceptible to accrual. Expenditures are recorded when the related fund liability is incurred, except for principal and interest on general long-term debt, claims and judgments, and compensated absences, which are recognized as expenditures to the extent they have matured.

G. SUPPORTING FINANCIAL DOCUMENTATION

CRC Staff Organizational Chart – See Exhibit 1

Personnel Cost Worksheet - See Exhibit 2

Schedule to Compute Employee Benefit Cost Pool Rate - See Exhibit 3

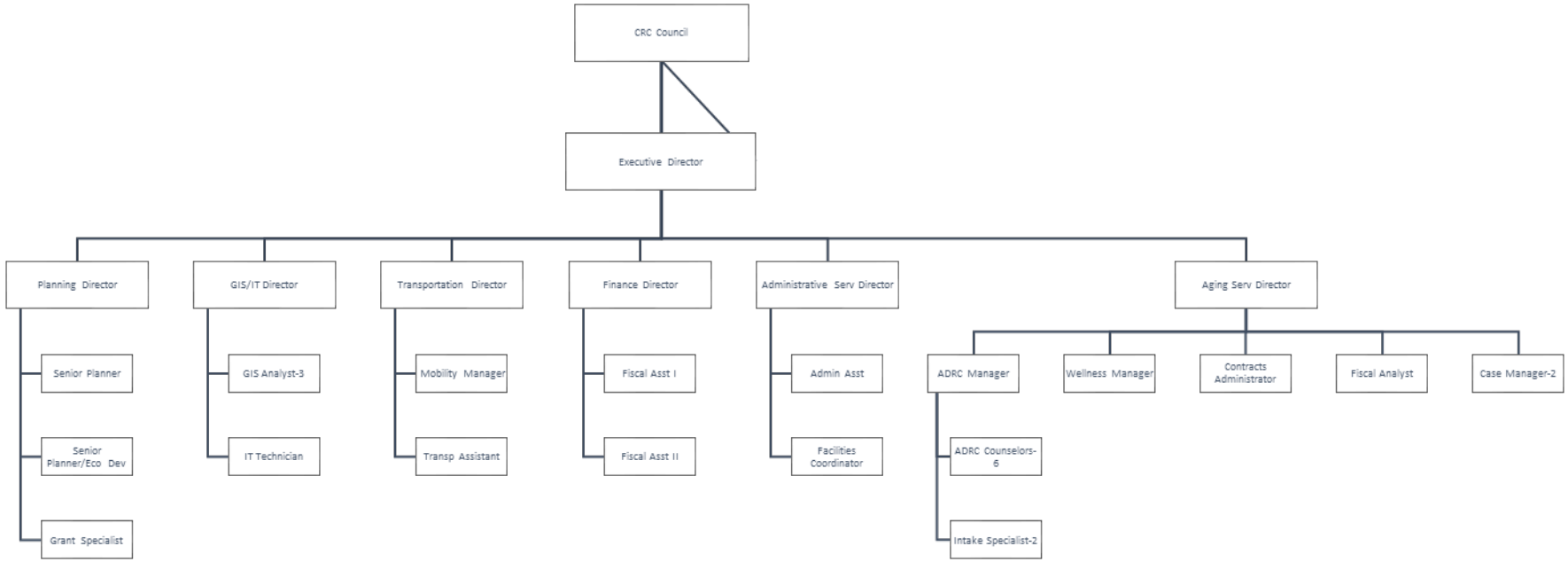
Indirect Cost Salaries Worksheet – See Exhibit 4

Schedule to Compute Indirect Cost Rate – See Exhibit 5

H. CERTIFICATE OF INDIRECT COSTS FOR FY 2019

I. CERTIFICATE OF INDIRECT COSTS FOR FY 2018 & ACKNOWLEDGEMENT

Coastal Regional Commission
Organizational Chart
Fiscal Year 2019



COASTAL REGIONAL COMMISSION PERSONNEL COSTS WORKSHEET FY19

POSITION	ANNUAL SALARY	HOLIDAY LEAVE	PTO LEAVE	EMERGENCY LEAVE	CHARGEABLE SALARY	FICA	TOTAL INSURANCE	RETIREMENT	TOTAL COST
EXECUTIVE DIRECTOR	184,207	8,502	11,513	2,834	161,358	9,401	12,174	24,818	$230,600
ADMINISTRATIVE SRV DIRECTOR	84,531	3,901	6,502	1,300	72,827	5,650	8,921	9,698	$108,800
PUBLICATIONS SECRETARY	45,619	2,105	2,391	702	40,421	2,795	8,669	5,428	$62,510
FACILITY MAINTENANCE COORD	39,815	1,838	1,531	613	35,833	2,566	6,168	5,364	$53,913
SUBTOTAL - ADMINISTRATIVE	**$ 354,171**	**$ 16,346**	**$ 21,937**	**$ 5,449**	**$ 310,439**	**$ 20,413**	**$ 35,932**	**$ 45,307**	**$ 455,823**
FINANCE DIRECTOR	99,608	4,597	7,662	1,532	85,816	6,450	9059	13420	$128,536
AGING FISCAL ANALYST	55,278	2,551	3,189	850	48,687	3,665	6332	5789	$71,064
FISCAL ASSISTANT I	20,202	699	1,777	311	17,414	1,392	3619	2520	$27,733
FISCAL ASSISTANT I	17,246	531	663	265	15,787	1,319	3102	2151	$23,818
FISCAL ASSISTANT II	48,249	2,227	4,802	742	40,478	3,415	6,266	5,535	$63,466
SUBTOTAL - FINANCE	**$ 240,583**	**$ 10,605**	**$ 18,094**	**$ 3,701**	**$ 208,183**	**$ 16,242**	**$ 28,378**	**$ 29,415**	**$ 314,618**
PLANNING DIRECTOR	95,399	4,403	5,504	1,468	84,025	6,800	6,630	12853	$121,683
GRANT SPECIALIST	41,412	1,911	2,389	637	36,475	3,107	882	4,751	$50,152
SENIOR PLANNER	61,970	2,860	2,383	953	55,773	4,310	6,362	8,349	$80,991
ECO DEV / SENIOR PLANNER	54,286	2,505	2,088	835	48,857	4,153	918	7,314	$66,670
SUBTOTAL - PLANNING	**$ 253,067**	**$ 11,680**	**$ 12,364**	**$ 3,893**	**$ 225,129**	**$ 18,370**	**$ 14,792**	**$ 33,267**	**$ 319,496**
GIS MANAGER	80,471	3,714	5,765	1,238	69,755	5,702	6,416	10,842	$103,431
GIS ANALYST	50,770	2,343	2,929	781	44,716	3,465	6,287	6,459	$66,981
GIS Analyst	35,808	1,615	1,346	551	32,295	2,739	6,287	4,556	$49,389
GIS Analyst	37,492	1,730	1,442	577	33,743	2,868	959	4,770	$46,088
SUBTOTAL - GIS	**$ 204,540**	**$ 9,403**	**$ 11,482**	**$ 3,147**	**$ 180,509**	**$ 14,775**	**$ 19,948**	**$ 26,627**	**$ 265,889**
						0			
						0			
	0	0	0		0	0		0	
IT TECHNICIAN	29,908	1,846	769	615	26,677	2,288	3143	3,132	$38,471
SUBTOTAL - IT	**$ 29,908**	**$ 1,846**	**$ 769**	**$ 615**	**$ 26,677**	**$ 2,288**	**$ 3,143**	**$ 3,132**	**$ 38,471**
CASE MANAGER	45,475	2,099	2,186	700	40,490	2,847	8,625	5,217	$62,165
CASE MANAGER	47,308	2,183	1,820	728	42,578	3,619	6,201	4,954	$62,083
GATEWAY SPECIALIST	35,019	1,616	1,347	539	31,517	2,525	6,201	4,718	$48,463
WELLNESS MANAGER	56,949	2,628	3,286	876	50,159	3,710	6,291	7,673	$74,623
GATEWAY SPECIALIST PT	15,462	357	0	238	14,867	1,028	0	1,619	$18,110
AGING SERVICES DIRECTOR	90,572	4,180	5,748	1,393	79,250	5,957	8,722	12,202	$117,453
ACCESS MANAGER	53,862	2,486	5,283	829	45,264	3,730	896	7,257	$65,744
GATEWAY SPECIALIST	47,859	2,209	5,062	736	39,852	3,140	6,243	6,448	$63,690
GATEWAY SPECIALIST	36,045	1,664	3,206	555	30,621	2,373	6,163	4,100	$48,680
GATEWAY SPECIALIST	39,021	1,801	2,570	600	34,049	2,737	6,180	4,477	$52,415
CARE COORD MANAGER	59,911	2,765	3,485	922	52,739	4,227	6,278	8,072	$78,488
GATEWAY SPECIALIST	45,248	2,088	3,987	696	38,476	2,856	8,655	4,739	$61,497
GATEWAY SPECIALIST	39,643	1,830	1,525	610	35,678	2,380	8,456	5,127	$55,605
GATEWAY SPECIALIST PT	6,756			104	6,652	517	0	707	$7,980
SUBTOTAL - AGING	**$ 619,127**	**$ 27,906**	**$ 39,504**	**$ 9,525**	**$ 542,192**	**$ 41,647**	**$ 78,912**	**$ 77,309**	**$ 816,996**
MOBILITY MANAGER	61,486	2,838	2,365	946	55,338	3,730	11,439	6,747	$83,402
TRANSPORTATION DIRECTOR	96,285	4,444	5,555	1,481	84,805	7,163	6,477	10,084	$120,009
TRANSPORTATION FISCAL ANALYST	50,562	2,334	2,917	778	44,534	3,381	8542	5,295	$67,780
SUBTOTAL - TRANSPORTATION	**$ 208,334**	**$ 9,615**	**$ 10,837**	**$ 3,205**	**$ 184,676**	**$ 14,273**	**$ 26,458**	**$ 22,126**	**$ 271,191**
								$ -	
TOTAL CRC	**$ 1,909,730**	**$ 87,403**	**$ 114,987**	**$ 29,536**	**$ 1,677,805**	**$ 128,008**	**$ 207,564**	**$ 230,961**	**$ 2,482,484**

SYF 2019 Revised

COASTAL REGIONAL COMMISSION	
Schedule to Compute Employee Benefit Cost Pool Rate	
2019 BUDGET	
	2019 Budget
Released Time:	
Paid Time Off taken and accrued	$ 144,987
Emergency leave	28,536
Holiday pay	87,403
Jury Duty or Military leave	1,000
Extended Illness Bank	-
Total Released Time	261,926
Fringe Benefits Paid:	
Pension	233,461
Employer's FICA and Medicare	128,008
Unemployment Insurance	2,500
Health Insurance	179,856
Dental Insurance	10,991
Long-term disability	17,566
Worker's Compensation	4,400
Total Fringe Benefits Paid	576,782
Allocable Employee Benefits	$ 838,707
COMPUTATION OF EMPLOYEE BENEFIT RATE	
Gross Salaries	$ 1,939,730
Less: Released Time	(261,926)
Allocation base - chargeable salaries	$ 1,677,805
Employee Benefit Rate	49.99%

COASTAL REGIONAL COMMISSION
INDIRECT COST SALARIES WORKSHEET
FISCAL YEAR 2019

Position	Total Chargeable Salaries	Indirect Cost Pool	%	Direct Costs: Planning Grants	%	GIS Grants	%	Aging Grants	%	Transp Grants	%	Total
EXECUTIVE DIRECTOR	$ 161,358	161,358	100%		0%	-	0%	-	0%	-	0%	161,358
												-
ADMINISTRATIVE SRV DIRECTOR	$ 72,827	72,827	100%	-	0%	-	0%		0%	-	0%	72,827
												-
ADMINISTRATIVE ASSISTANT	$ 40,421	22,421	54%	5,000	13%	-	0%	13,000	33%		0%	40,421
FACILITY MAINTENANCE COORD	$ 35,833	35,833	100%	-	0%	-	0%	-	0%	-	0%	35,833
												-
FINANCE DIRECTOR	$ 85,816	85,816	100%		0%	-	0%	-	0%	-	0%	85,816
												-
FISCAL ASSISTANT I	$ 17,414	17,414	100%	-	0%	-	0%	-	0%		0%	17,414
												-
FISCAL ASSISTANT I	$ 15,787	15,787	100%	-	0%	-	0%	-	0%		0%	15,787
												-
FISCAL ASSISTANT II	$ 40,478	27,525	68%	-	0%	-	0%	-	0%	12,953	32%	40,478
												-
IT SYSTEM ANALYST-PT	$ 26,677	26,677	100%	-	0%	-	0%	-	0%	-	0%	26,677
												-
GIS/IT Director	$ 69,755	22,500	32%	-	0%	-	0%	-	0%	-	0%	22,500
												-
TOTAL	$ 566,366	$ 488,158	86%	$ 5,000		$ -		$ 13,000		$ 12,953		519,111

COASTAL REGIONAL COMMISSION
Schedule to Compute Indirect Cost Rate
2019 BUDGET

	2019 Budget
Salaries	$ 472,372
Fringe benefits	236,131
Contract Services	55,200
Travel	6,000
Travel commission car	6,000
Utilities	92,000
Telecommunications	16,000
Insurance	28,000
Postage	4,600
Meetings and seminars	5,000
Dues and subscriptions	12,000
Audit and accounting	28,000
Newsletter and annual report	3,000
Office supplies	16,000
Equipment lease and purchase	30,000
Equipment service & repairs	2,500
Computer license agreements	25,000
Building & lawn maintenance	30,000
Depreciation	72,455
Miscellaneous	4,000
Total Indirect Cost	$ 1,144,257
Indirect Cost Rate Calculation:	
Total Chargeable Salaries	$ 1,677,805
plus Fringe Benefits	832,707
	$ 2,510,512
Less: Salaries + Fringe Charged to I.C. Pool	(708,502)
Chargeable Salaries Plus F.B.	$ 1,802,010
Internal Cost Pool	$ 1,144,257
Chargeable Salaries + Fringe	1,802,010

CERTIFICATE OF INDIRECT COSTS
FY 2019

This is to certify that I have reviewed the indirect cost rate proposal prepared and maintained herewith and to the best of my knowledge and belief:

(1) All costs included in this proposal dated February 28, 2018 to establish indirect costs rate(s) for July 1, 2018 – June 30, 2019 are allowable in accordance with the requirements of the Federal award(s) to which they apply and OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (codified at 2 C.F.R. Part 200) Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

(2) All costs included in this proposal are properly allocable to Federal awards on the basis of a beneficial or causal relationship between the expenses incurred and the agreements to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently and the Federal Government will be notified of any accounting changes that would affect the predetermined rate.

(3) The indirect cost rate calculated within the proposal is 63.50 %, which was calculated using a direct cost base type of Salary and Fringe. The calculations were based on budgeted costs for fiscal year 2019 to obtain a federal indirect cost billing rate for fiscal year 2019.

(4) All documentation supporting the indirect cost rate identified above must be retained by the Recipient. This rate should be reviewed and validated as part of the Recipient's annual financial audit.

Subject to the provisions of the Program Fraud Civil Remedies Act of 1986, (31 USC 3801 et seq.), the False Claims Act (18 USC 287 and 31 USC 3729); and the False Statement Act (18 USC 1001), I declare to the best of my knowledge that the foregoing is true and correct.

Organization Name: _Coastal Regional Commission_____
Signature: _____Signature on file_____
Name of Authorized Official: _Lena Geiger_____
Title: __Finance Director_____
Email Address and Phone: _lgeiger@crc.ga.gov 912-437-0820_____
Date of Execution: ___February 28, 2018_____

AREA PLAN ATTACHMENTS

ATTACHMENTS A - ACL GOALS AND AAA OBJECTIVES CHARTS

ATTACHMENTS B - LOCATION OF SERVICES CHARTS

- **Chart B #1 – Home and Community Based Services (HCBS)**
- **Chart B #2 – Access Services**
- **Chart B #3 – Community Care Services Program (CCSP)**

ATTACHMENTS C - COMPLIANCE DOCUMENTS

- **C-1.a – GA DHS DAS Request for Advance Payments Against Contracts Letter**
- **C-1.b – GA DHS DAS Request for Advance Letter**
- **C-1.c – Request for Advance Worksheet**
- **C-1.d – Letter of Bond Coverage**
- **C-2 – Standard Assurances**
- **C-3 – Letter(s) Requesting a Waiver of Standard Assurances**
- **C-4 – Board Resolution**

ATTACHMENTS D - REQUIRED PLANS **(No Required Plans requested to be included in the SFY 2018 Area Plan Submittal.)**

ATTACHMENT E - CERTIFICATION OF BUDGET SUBMITTAL

ATTACHMENT F - TITLE III FEDERAL ALLOCATION AND MATCH ANALYSIS (Excel)

ATTACHMENT G - AREA PLAN PROVIDER SITE LIST

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS

As required, Georgia's State Plan includes measurable objectives that address focus areas outlined by the United States Department of Health and Human Services Administration for Community Living. The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. The DAS developed Objectives under two of the focus areas for each of Georgia's AAAs to accomplish under its oversight: ***OAA Core Programs*** and ***Participant-Directed/Person-Centered Planning***.

The Goals, Strategies and Performance Metrics remain written in the AAA Area Plan as they are written in the Georgia State Plan, including yearly dates and numbering. AAAs should apply each Objective to its Planning and Service Area (PSA) and make no changes in the way it is written. *For the entire October 1, 2015 – September 30, 2019 Georgia State Plan, visit the DAS website and click on Publications.* http://aging.ga.gov The State Plan approved objectives and strategies to achieve these goals and to measure performance are listed below and are specifically stated in each of the following respective charts:

OAA Core Programs (OAA CP) Focus Area Goals

OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need

- (AAA #1) OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates

OAA CP Goal #2 – Create a Statewide Focus on Reaching Underserved Persons

- (AAA #2) OAA CP G#2/Objective #2:1 – Develop an Aging Network that Reaches Underserved Persons Across the State
- (AAA #3) OAA CP G#2/Objective #2:2 – Promote Greater Access to Waiver Services in Underserved/Rural Parts of the State

OAA CP Goal #3 - Expand Opportunities for Transportation in Underserved Areas of Georgia

- (AAA #4) OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities

OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible

- (AAA #5) OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services

OAA CP Goal #10 - Increase the Numbers of Individuals Served by GeorgiaCares from "Targeted Populations"

- (AAA #6) OAA CP G#10/Objective #10 – Increase the Number of Client Contacts

OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)

- (AAA #7) OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion

Participant Directed/Person-Centered Planning (PD/PC P) Focus Area Goals

PD/PC P Goal #2 - Develop and Implement a Person-Centered Approach to Service Mix

- (AAA #8) PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based

PD/PC P Goal #3 - Maximize the Variety of Approaches to Support Consumer Control and Choice

- (AAA #9) PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology as an Option in Place of Services

PD/PC P Goal #4 - Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults

- (AAA #10) PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops and Utilize Technology to Increase Professional Capacity

PD/PC P Goal #5 - Support Grandparents and Other Relative Caregivers to Maximize Family Independence

- (AAA #11) PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems

PD/PC P Goal #6 - Ensure Maximum Access and Efficient Delivery of Home and Community Based Services (HCBS) to Older Adults, Persons with Disabilities and Caregivers

- (AAA #12) PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration

PD/PC P Goal #7 - Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

- (AAA #13) PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

PD/PC P Goal #8 - Empower Residents of Facilities to Fully Participate in Directing Their Care

- (AAA #14) PD/PC P G#8/Objective #8:1 – Develop and Implement a Plan to Increase Resident and Family Self-Advocacy
- (AAA #15) PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options, Including MFP

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS
OAA Core Programs (OAA CP) Focus Area Goals

AAA #1	
OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need	
OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates by September 30, 2019	
	Strategies
1.	Expand fee-for-service program model (example: Evidence Based Programs, Case Management, Community Living Program, Senior Centers) by 2019.
2.	Implement evidence-based hospital transition programs in all AAAs by 2019.
3.	All AAAs have business plan with a regular review process by 2019.

	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	100% of the AAAs will receive business plan training by 2019.	Coastal AAA received business plan training during FY2015 & 2016.
2.	100% of AAAs will implement business plans by 2019.	Coastal AAA has developed and implemented a business plan.
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	Coastal AAA is exploring expansion of our Care Transition Program and other fee for service options.
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	Coastal AAA is actively exploring expansion of our Care Transition Program to other partner hospitals
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	100% of the AAAs will receive business plan training by 2019.	Coastal AAA received business plan training during FY2015 & 2016
2.	100% of AAAs will implement business plans by 2019.	Coastal AAA has developed and implemented a business plan.
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	Coastal AAA is currently working on implementation plans to expand Care Transitions to a new hospital: St. Joseph's/Candler.
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	Coastal AAA is currently working to expand Care Transitions to a new hospital, St. Joseph's/Candler. A 100% increase over last year.
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	Average funds received via Care Transitions work remain steady. No substantial change at this time.
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	100% of the AAAs will receive business plan training by 2019.	Coastal AAA received business plan training during FY2015 & 2016
2.	100% of AAAs will implement business plans by 2019.	Coastal AAA has developed and implemented a business plan.
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	Coastal AAA established a pilot program with St. Joseph's/ Candler to provide Care Transitions services for six months. The pilot ends in

AAA #1 **OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need** **OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates by September 30, 2019**		
		March. Beginning in April Candler will have the option to purchase Care Transition Services from Coastal as fee for service.
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	Coastal AAA has expanded Care Transitions Services to the Savannah area thru the pilot program with Candler, increase from one hospital system to two systems.
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	An increase in fee for service funding is pending the outcome of the Savannah/ Candler pilot. Funding from the Brunswick hospital system remains steady. The partnership with St. Joseph/ Candler, the Savannah hospital system is on hold while the hospital explores grant funding to continue the project. The Brunswick hospital system continues to pay $450/ patient for the 30-day intervention.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	100% of the AAAs will receive business plan training by 2019.	Coastal AAA received business plan training during FY2015 & 2016
2.	100% of AAAs will implement business plans by 2019.	Coastal AAA has developed and implemented a business plan.
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	Coastal AAA has a fee for service model for the following programs: Care Transitions, Care Consultation, Case Management and CDSMP.
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	Coastal AAA's Care Transitions Program serves Glynn, McIntosh and Camden Counties through a partnership with one hospital system, Southeast Georgia Health Systems.
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	Funding from the Brunswick hospital system remains steady. The partnership with St. Joseph/ Candler, the Savannah hospital system is on hold while the hospital explores grant funding to continue the project. The Brunswick hospital system continues to pay $450/ patient for the 30-day intervention.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	100% of the AAAs will receive business plan training by 2019.	
2.	100% of AAAs will implement business plans by 2019.	
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	

AAA #1 **OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need** **OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates by September 30, 2019**		
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #2 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** **OAA CP G#2/Objective #2:1 - Develop an Aging Network that Reaches Underserved Persons Across the State by September 30, 2019 (Revised: December 2017)**		
	Strategies	
1.	Identify and prioritize no more than two (2) potential underserved older adult (age 60 and older) or caregiver populations from the list below to be reached: • Limited English Speaking/Sensory Impaired (LEPSI) - the AAA may choose to select a subset of the LEPSI population; for example: Hispanic, hard of hearing, etc. • Rural • Frail (score of 2+ on three or more ADLs) • Below poverty • Veterans	
2.	Develop work plan to increase access to services for each underserved population(s).	
3.	Develop partnerships that facilitate access to services for the identified underserved population(s).	
4.	Focus network activity to address the needs of the identified underserved population(s).	
5.	Develop and implement training for community partners to aid in outreach and service provision to the identified underserved population(s).	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	

AAA #2 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** **OAA CP G#2/Objective #2:1 - Develop an Aging Network that Reaches Underserved Persons Across the State by September 30, 2019 (Revised: December 2017)**		
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	
	Performance Metrics	**Baseline as of June 30, 2018 and SFY 2019 Status Update** **(July 1, 2018 – January 31, 2019)**
1.	Increase number of underserved individuals served by 10% after setting baseline as of July 1, 2018.	LEPSI individuals served baseline data is 148, during this reporting period Coastal AAA served 347 individuals with LEPSI, an increase of 134%. Veterans served baseline data is 113, during this reporting period 142 veterans have been served, an increase of 25%.
2.	Increase number of community partnerships that support service expansion to the identified underserved population(s) by 10% after setting baseline as of July 1, 2018.	Baseline data as of July 2018 is 24 partners. Coastal ADRC added 28 new partners during the reporting period for a total of 52, 116% increase over the previous fiscal year.
3.	Number of activities that occur between July 1, 2018 and January 31, 2019 that support expansion to the identified underserved population(s).	Coastal AAA completed 41 outreach activities to support expansion to underserved populations during the reporting period.
4.	Number of trainings provided to partner agencies between July 1, 2018 and January 31, 2019 that support service expansion to the identified underserved population(s).	Coastal AAA completed 10 trainings to underserved populations during the reporting period.
	Performance Metrics	**SFY 2020 Update**

AAA #2 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** **OAA CP G#2/Objective #2:1 - Develop an Aging Network that Reaches Underserved Persons Across the State by September 30, 2019 (Revised: December 2017)**		
		(February 1, 2019 – September 30, 2019)
1.	Increase number of underserved individuals served by 10% after setting baseline as of July 1, 2018.	
2.	Increase number of community partnerships that support service expansion to the identified underserved population(s) by 10% after setting baseline in as of July 1, 2018.	
3.	Number of activities that occur between February 1, 2019 and September 30, 2019 that support expansion to the identified underserved population(s).	
4.	Number of trainings provided to partner agencies between February 1, 2019 and September 30, 2019 that support service expansion to the identified underserved population(s).	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #3 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** ~~**OAA CP G#2/Objective #2:2 - Promote Greater Access to CCSP Waiver Services in Underserved/Rural Parts of the State by September 30, 2019**~~		
	Strategies	
1.	Develop effective ways to address potentially-eligible consumers' concerns related to cost-share and estate recovery.	
2.	Provide training for ADRC and Case Management staff to deliver consistent messages about cost share and estate recovery.	
	SFY 2016 Status **(July 1, 2015 – January 31, 2016)**	
	Coastal ADRC and Case Management staff will participate in DAS training on cost chare and estate recovery as offered.	
	SFY 2017 Update **(February 1, 2016 – January 31, 2017)**	
	N/A as it pertains to CCSP	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #4 **OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia** **OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019** **(Revised: December 2017)**	
	Strategies
1.	Pilot at least two innovations that improve local transportation options for older adults and persons living with disabilities.
2.	Implement at least three volunteer transportation programs in Georgia that are sustainable.
3.	Develop or enhance partnerships with local transportation organizations (for-profit and nonprofit) to expand transportation options for vulnerable populations.

	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**SFY 2018 Update**

AAA #4 **OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia** **OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019** **(Revised: December 2017)**		
		(February 1, 2017 – January 31, 2018)
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**Baseline as of June 30, 2018 and SFY 2019 Status Update** **(July 1, 2018 – January 31, 2019)**
1.	Number of innovative projects that seek to improve local transportation options.	Coastal AAA is operating a pilot transportation project providing fixed-route transportation to eight senior-populated housing complexes in Glynn County.
2.	Documentation of lessons learned from the innovative projects that seek to improve local transportation options.	The pilot will extend through the end of this fiscal year. Coastal AAA is closely monitoring the project and will gather feedback from key stakeholders and customers at the pilot to fully evaluate the effective of the pilot.
3.	Number of volunteer programs developed or expanded.	N/A
4.	Number of volunteer programs sustained at ***1 year*** and 2 years.	N/A
5.	Number of partnerships developed that support transportation innovations.	Coastal AAA is currently working with eight partners on the transportation pilot.
6.	Number of enhancements to existing partnerships with local transportation organizations that support transportation innovations.	There are no enhancements to existing partnerships to report at this time.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Number of innovative projects that seek to improve local transportation options.	
2.	Documentation of lessons learned from the innovative	

AAA #4 **OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia** **OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019** **(Revised: December 2017)**		
	projects that seek to improve local transportation options.	
3.	Number of volunteer programs developed or expanded.	
4.	Number of volunteer programs sustained at 1 year and ***2 years***.	
5.	Number of partnerships developed that support transportation innovations.	
6.	Number of enhancements to existing partnerships with local transportation organizations that support transportation innovations.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #5 **OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible** **OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services by September 30, 2019**		
	Strategies	
1.	Develop co-op with local organizations (Boy Scouts; home improvement stores; high schools; tech programs; and faith-based communities).	
2.	Increase home modification/home repair services access statewide.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options.
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**

AAA #5 **OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible** **OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services by September 30, 2019**		
1.	Home modification/home repair services are available in all 12 AAAs by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options. Services will be available in all nine counties of the Coastal region by 2019.
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options.
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options. Home modification services are available in all nine counties of the Coastal region, predominately through Veteran Affairs, Centers for Independent Living, Community Action Authorities and local government programs.
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options. Home modification services are available in all nine counties of the Coastal region, predominately through Veteran Affairs, Centers for Independent Living, Community Action Authorities and local government programs.
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	Coastal provides referrals to agencies offering home modification programs. Coastal AAA also works to expand our services data base to include home modification service options.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	

AAA #5 **OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible** **OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services by September 30, 2019**		
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #6 **OAA CP Goal #10 - Increase the Numbers of Individuals Served by GeorgiaCares from "Targeted Populations"** **OAA CP G#10/Objective #10 – Increase the Number of Client Contacts by September 30, 2019**		
	Strategies	
1.	Market the DAS toll-free number to increase calls routed to the local GeorgiaCares programs. Provide various methods of contact; one-on-one, mail, telephone, e-mail, GeorgiaCares website (www.mygeorgiacares.org) for clients seeking Medicare assistance.	
2.	Expand reach to limited English proficient populations by recruiting bilingual volunteers and use the Language Line services to assist clients.	
3.	Maintain off-site counseling stations in every county to provide services locally to clients.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase the number of client contacts by 3% each year.	Coastal AAA maintains at least one offsite counseling site in each of our nine counties. Coastal uses Language Line Services as needed. Coastal AAA served 3,631 clients through GeorgiaCares FY2015 and experienced 4,609 client contacts through January 2016 - Goal met
2.	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines).	Standard Met - Coastal will continue to meet the GaCares standard of promptness requirement.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase the number of client contacts by 3% each year.	Client contact data is available in Harmony. Reports on this data are not available at this time.
2.	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines).	Standard Met - Coastal will continue to meet the GaCares standard of promptness requirement.
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Increase the number of client contacts by 3% each year.	Coastal AAA's GeorgiaCares Program is operating under a waiver to provide limited services during this transition period. Goal is pending. Coastal is operating under a waiver to provide limited GeorgiaCares services during FY2018. Consequently, there will not be an increase in the number of client contacts this fiscal year as compared to FY2017. Coastal will cease to operate this program in FY2019.
2.	Maintain 2-day standard of promptness for returning client calls	While GeorgiaCares calls for the Coastal region are currently be

AAA #6 **OAA CP Goal #10 - Increase the Numbers of Individuals Served by GeorgiaCares from "Targeted Populations"** **OAA CP G#10/Objective #10 – Increase the Number of Client Contacts by September 30, 2019**		
	(GeorgiaCares Standards and Guidelines).	handled by the Three Rivers AAA, the calls are answered within the SOP. Standard Met.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase the number of client contacts by 3% each year.	Program is operated at the state level; Coastal has no data to report.
2.	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines).	Program is operated at the state level; Coastal has no data to report.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase the number of client contacts by 3% each year.	
2.	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines).	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #7 **OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)** **OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion by September 30, 2019**		
	Strategies	
1.	Develop collaboration between GeorgiaCares, ADRC and Health and Wellness staff to conduct outreach and educate Medicare beneficiaries.	
2.	Establish and foster community partnerships with organizations and agencies serving Medicare beneficiaries.	
3.	Increase marketing efforts for the GeorgiaCares program to improve brand awareness.	
4.	Continue partnership with Fort Valley State University mobile information technology center to reach individuals in rural counties.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	Coastal AAA will continue to reach the performance measures established for the program. Coastal AAA completed 1,995 (MSP) and (LIS) applications thru January 30, 2016.
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	Coastal AAA has established at least one offsite counseling site in each county. Coastal had 9 sites in FY2015 and has 12 sites to date.
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	Coastal AAA has established partnerships for the GeorgiCares Program in each of our nine counties. To date we have 56 new partnerships.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	Contacts are expected to increase as GeorgiaCares and ADRC staff become more familiar with Harmony. However, it should be noted that Coastal is currently undergoing a change in staff in our GeorgiaCares program that will likely impact our number of contacts as well. Coastal's new GeorgiaCares Coordinator will work closely with the GeorgiaCares staff in the state office to identify strategies to improve these outcomes.
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	Coastal has established at least one off-site counseling site in each of its nine counties of service.
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	Coastal has established at least one new partnership in each of its nine counties of service.
	Performance Metrics	**SFY 2018 Update**

AAA #7 **OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)** **OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion by September 30, 2019**		
		(February 1, 2017 – January 31, 2018)
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	Coastal AAA's GeorgiaCares Program is operating under a waiver to provide limited services during this transition period. Goal is pending. Coastal is operating under a waiver to provide limited GeorgiaCares services during FY2018. Consequently, there will not be an increase in the number of client contacts this fiscal year as compared to FY2017. Coastal will cease to operate this program in FY2019.
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	Coastal AAA's GeorgiaCares Program is operating under a waiver to provide limited services during this transition period.
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	Coastal has established at least one new partnership in each of its nine counties of service.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	Program is operated at the state level; Coastal has no data to report.
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	Program is operated at the state level; Coastal has no data to report.
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	Program is operated at the state level; Coastal has no data to report.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state	

AAA #7 **OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)** **OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion by September 30, 2019**		
	during SFY 2016 – SFY 2020.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…
Participant Directed/Person-Centered Planning (PD/PC P) Focus Area Goals

AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**	
	Strategies
1.	Analyze and assess current wait lists and how they are used.
2.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
3.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2016 Status **(July 1, 2015 – January 31, 2016)**
	Coastal AAA staff have participated in DAS sponsored workgroup, training and webinar activities on the RAT development. Coastal AAA ADRC Program Manager is analyzing our local waiting list data and developing internal procedures for waiting list management and referral to case management. During FY16 Coastal AAA attended a training session provided by DAS on Support Options and has participated in DAS lead conference calls to discuss Support Options and Home Modifications Services. Coastal is exploring ways to implement a Support Options Program and track referrals for home modification services for FY2017.
	Strategies
1.	Analyze and assess current wait lists and how they are used.
2.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
3.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2017 Update **(February 1, 2016 – January 31, 2017)**
	Coastal AAA ADRC Program Manager analyzes local waiting list data on a regular basis and uses this process to establish internal procedures for waiting list management. Coastal's ADRC utilizes guidance from DAS in this process and makes sure all staff are trained on Waiting List Prioritization. Coastal AAA staff participated in the WL Prioritization Training hosted by DAS in Dec 2016 Coastal AAA attended a training session provided by DAS on Support Options and has participated in DAS conference calls to discuss

AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**	
	Support Options and Home Modifications Services. Coastal continues to explore ways to implement a Support Options Program and track referrals for home modification services. Coastal AAA is not utilizing the RAT at this time.
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2018 Update **(February 1, 2017 – January 31, 2018)**
	Coastal AAA ADRC Program Manager analyzes local waiting list data on a regular basis and uses this process to establish internal procedures for waiting list management. Coastal's ADRC utilizes guidance from DAS in this process and makes sure all staff are trained on Waiting List Prioritization. Coastal AAA attended a training session provided by DAS on Support Options and has participated in DAS conference calls to discuss Support Options and Home Modifications Services. Coastal continues to explore ways to implement a Support Options Program and track referrals for home modification services. Coastal AAA is not utilizing the RAT at this time.
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2019 Update **(February 1, 2018 – January 31, 2019)**
	Coastal AAA ADRC Program Manager analyzes local waiting list data on a regular basis and uses this process to establish internal

	AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**
	procedures for waiting list management. Coastal's ADRC utilizes guidance from DAS in this process and makes sure all staff are trained on Waiting List Prioritization and DAS Triage protocol. Coastal AAA has attended training sessions provided by DAS on Support Options and has participated in DAS conference calls to discuss Support Options and Home Modifications Services. Coastal continues to explore ways to implement a Support Options Program and track referrals for home modification services. Coastal ADRC is not utilizing the RAT at this time. The RAT is used as a secondary assessment by Case Management .
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2020 Update **(February 1, 2019 – September 30, 2019)**

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #9 **PD/PC P Goal #3 – Maximize the Variety of Approaches to Support Consumer Control and Choice PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology (AT) as an Option in Place of Services by September 30, 2019**		
	Strategies	
1.	Implement an assistive technology program.	
2.	Establish a baseline of number of HCBS consumers referred for AT.	
3.	Establish a baseline of number of HCBS consumers currently using AT.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	All AAAs have AT program implemented and functioning by 2019.	Coastal AAA has a functional AT lab and program for offering AT.
2.	Increase number of consumers referred for AT by 25% by 2019.	Will develop a baseline for AT referrals
3.	Increase number of consumers using AT by 25% by 2019.	Will develop a baseline for consumers using AT
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	All AAAs have AT program implemented and functioning by 2019.	Coastal AAA has a functional AT lab and program for offering AT.
2.	Increase number of consumers referred for AT by 25% by 2019.	75 consumers were referred for AT during the data collection period.
3.	Increase number of consumers using AT by 25% by 2019.	72 consumers were provided AT for use during the same period.
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	All AAAs have AT program implemented and functioning by 2019.	Coastal AAA has a functional AT lab and program for offering AT.
2.	Increase number of consumers referred for AT by 25% by 2019.	90 consumers were referred for AT during the data collection period.
3.	Increase number of consumers using AT by 25% by 2019.	54 consumers were provided AT for use during the same period, 32 consumer referrals for AT are pending.
	Performance Metrics	**SFY 2019 Update (February 1, 2018 – January 31, 2019)**
1.	All AAAs have AT program implemented and functioning by 2019.	Coastal AAA has a functional AT lab and program for offering AT.
2.	Increase number of consumers referred for AT by 25% by 2019.	Coastal AAA referred 148 consumers for AT during the reporting period, a 64% increase over the previous reporting period.
3.	Increase number of consumers using AT by 25% by 2019.	Coastal AAA provided AT to 69 consumers, a 27% increase over the previous reporting period.
	Performance Metrics	**SFY 2020 Update (February 1, 2019 – September 30, 2019)**
1.	All AAAs have AT program implemented and functioning by 2019.	
2.	Increase number of consumers referred for AT by 25% by 2019.	
3.	Increase number of consumers using AT by 25% by 2019.	

AAA #9 **PD/PC P Goal #3 – Maximize the Variety of Approaches to Support Consumer Control and Choice** **PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology (AT) as an Option in Place of Services by September 30, 2019**

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #10 **PD/PC P Goal #4 – Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults** **PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops, and Utilize Technology to Increase Professional Capacity by September 30, 2019**		
	Strategies	
1.	Facilitate conference calls and webinars between Health and Wellness coordinators and caregiver specialists to increase cross referrals between programs.	
2.	Co-sponsor an annual financial exploitation summit with other organizations.	
3.	Participate in DAS-sponsored Financial Exploitation Work Team.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify baseline of class leaders and Master Trainers for each AAA.	Coastal AAA has 4 class leaders and 4 Master Trainers, for a total of 8 Powerful Tools for Caregivers staff/ volunteers. (The 4 Master Trainers are also available to act as class leaders.)
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	Coastal AAA has 4 class leaders and 4 Master Trainers, for a total of 8 Powerful Tools for Caregivers staff/ volunteers. (The 4 Master Trainers are also available to act as class leaders.)
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	Coastal AAA has 3 PTC master trainers and class leaders.

AAA #10 **PD/PC P Goal #4 – Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults** **PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops, and Utilize Technology to Increase Professional Capacity by September 30, 2019**		
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	Coastal has not collected data for this baseline, as Coastal ADRC is not using the RAT to assess family caregivers at this time.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	Coastal currently has three (3) active class leaders and one (1) PTC Master Trainer. Currently, two of the class leaders are pursuing Master Trainer certification.
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	Coastal has not collected data for this baseline, as Coastal ADRC is not using the RAT to assess family caregivers at this time.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #11 **PD/PC P Goal #5 – Support Grandparents and Other Relative Caregivers to Maximize Family Independence PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems by September 30, 2019**		
	Strategies	
1.	Meet at least twice per year with state's Kinship Care Coordinators.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	Coastal AAA is providing support and technical assistance to multiple Kinship Care Programs in the Coastal region.
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	Coastal AAA established a new partnership with McCares during FY2016 for the expansion of Kinship Services in McIntosh County.
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	Coastal AAA is providing support and technical assistance to multiple Kinship Care Programs in the Coastal region.
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	Coastal AAA is providing support and technical assistance to Kinship Care Programs in the Coastal region. Coastal supports the Coastal Coalition for Children's Grandparents Connection that serves Glynn County and the McCares Grandparents Program that serves McIntosh County. We provide funding through mini-grants that provide summer camp for grandchildren and educational materials and workshops for grandparents.
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	During FY2017 Coastal AAA referred kinship families to kinship programs and provided outreach to kinship families to increase linkage to kinship programs and resources. Coastal hopes to track this data in Harmony during FY2018.
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	Coastal AAA is providing support and technical assistance to Kinship Care Programs in the Coastal region. Coastal supports the Coastal Coalition for Children's Grandparents Connection that serves Glynn County and the McCares Grandparents Program that serves McIntosh County.
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	Coastal AAA refers kinship families to kinship programs and provides outreach to kinship families to increase linkage to kinship programs

AAA #11 **PD/PC P Goal #5 – Support Grandparents and Other Relative Caregivers to Maximize Family Independence PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems by September 30, 2019**		
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	and resources. Coastal is exploring ways to track this data in Harmony.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	Coastal AAA is providing support and technical assistance to Kinship Care Programs in the Coastal region. Coastal supports the Coastal Coalition for Children's Grandparents Connection that serves Glynn County and the McCares Grandparents Program that serves McIntosh County.
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	While Coastal AAA supports local kinship programs, we do not contract with a service provider for the provision of these services, nor do we operate a kinship program internally.
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	Coastal AAA refers kinship families to kinship programs and provides outreach to kinship families to increase linkage to kinship programs and resources. Data is not currently tracked in WellSky. "Kinship" is not a call topic or a resolutions option on the call side in WellSky.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #12 **PD/PC P Goal #6 – Ensure Maximum Access and Efficient Delivery of Home and Community Based Services to Older Adults, Persons with Disabilities, and Caregivers** **PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration by September 30, 2019**		
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	Coastal AAA ADRC Program Manager has analyzed our local waiting list data and developed internal procedures for waiting list management and referral for HCBS Services. Providers have received training and technical assistance regarding client prioritization.
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	Coastal AAA ADRC Program Manager has analyzed our local waiting list data and developed internal procedures for waiting list management and referral for HCBS Services. Providers have received training and technical assistance regarding client prioritization.
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	Coastal AAA is providing case management services to clients meeting the target criteria as evident by risk levels established during the assessment process. Coastal's case management services are structured to provide the right service, at the right time in the right amount to aid the client in remaining independent or maintaining the level of desired independence.
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target	

AAA #12 **PD/PC P Goal #6 – Ensure Maximum Access and Efficient Delivery of Home and Community Based Services to Older Adults, Persons with Disabilities, and Caregivers** **PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration by September 30, 2019**		
	criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
	Strategies	
1.	Present available evidence-based programs to health care professionals via association meetings, conference calls, conferences, etc.	
2.	Partner with local, state and national organizations to increase referrals and promote continuous quality improvement for evidence-based programs in Georgia.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	Coastal AAA provided CDSMP, Power Tools for Caregivers, DSMP, Matter of Balance and Thai Chi workshops and / or class leader trainings during FY2016. No baseline data is available. During FY2017 referrals will be tracked in Harmony or internally using SharePoint. Program Expansion is ongoing using a multifaceted approach to identifying and recruiting new partners and volunteers.
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	Coastal AAA has established partnerships with local hospitals and health centers, public health departments, and physicians to promote evidence-based programs. We have approximately 40 partners.
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	Coastal AAA will review FY2016 data on retention rate to establish a baseline. Program retention is an ongoing effort, therefore the Wellness Program Manager will seek to expand training efforts, increase outreach to local communities, and work closely with current active lay leaders.
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	Coastal AAA currently contracts with 1 agency to provide fee-for-service CDSMP
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	Coastal AAA currently offers evidence-based wellness programs in all counties
6.	Increase statewide marketing of evidence-based health and wellness programs.	Continue region-wide marketing of evidence-based health and wellness programs.

AAA #13

PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019

	Performance Metrics	SFY 2017 Update (February 1, 2016 – January 31, 2017)
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	Coastal AAA provided CDSMP, Power Tools for Caregivers, DSMP, Thai Chi workshops and / or class leader trainings during FY2017. The data is recorded in Harmony. No reports are available at this time.
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	Coastal AAA has established partnerships with local hospitals and health centers, public health departments, and physicians to promote evidence-based programs. We have approximately 40 partners.
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	During FY2017 to date, Coastal has conducted 12 evidence based workshops and served 85 individuals through our evidence based programs. ADRC staff make referrals directly to our Wellness Manager. The outcome of these referrals are tracked by the Wellness Program Manager.
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	Coastal AAA currently contracts with 1 agency to provide fee-for-service CDSMP.
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	Coastal AAA currently offers evidence-based wellness programs in all counties
6.	Increase statewide marketing of evidence-based health and wellness programs.	Continue region-wide marketing of evidence-based health and wellness programs.
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	Coastal AAA has established partnerships with local hospitals and health centers, public health departments, and physicians to promote evidence-based programs. We have approximately 42 partners.
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	During FY2018 to date, Coastal has conducted 10 evidence based workshops and served 159 individuals through our evidence based programs. ADRC staff make referrals directly to our Wellness Manager. The outcome of these referrals are tracked by the Wellness Program Manager.

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	Coastal has served 159 participants in FY2018 vs. 85 in FY2017, an 87% increase.
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	Coastal AAA contracted with 1 agency to provide fee-for-service CDSMP, Humanities Foundation.
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	Coastal AAA currently offers evidence-based wellness programs in all counties
6.	Increase statewide marketing of evidence-based health and wellness programs.	Continue region-wide marketing of evidence-based health and wellness programs. Training and support from DAS has helped with the development and expansion of our EBPs.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	Coastal ADRC currently screens callers who may be interested in EBPs. Information is sent to anyone interested in the programs. Anyone who is interested is captured in SharePoint and Wellness Program Manager contact individuals when a workshop becomes available. There are currently 2 consumers on the waiting list for EBP's at this time.
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	Continue to partner and collaborate with healthcare systems to offer EBPs in the community. We have approximately 45 partners, a 7% increase over the previous reporting period.
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	Coastal served 91 participants. Seventy- three (73) completed four or more of the 6-week sessions, an 80% retention rate.
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	Coastal AAA contracted with 1 agency to provide fee-for-service CDSMP, Humanities Foundation.
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	Coastal AAA currently offers evidence-based wellness programs in all counties. Workshops are offered based on availability of volunteers.
6.	Increase statewide marketing of evidence-based health and wellness programs.	Continue region-wide marketing of evidence-based health and wellness programs.

AAA #13

PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019

	Performance Metrics	SFY 2020 Update (February 1, 2019 – September 30, 2019)
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	
6.	Increase statewide marketing of evidence-based health and wellness programs.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #14 **PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care** **PD/PC P G#8/Objective #8:1 – Develop and Implement a Plan to Increase Resident and Family Self-Advocacy by September 30, 2019**		
	Strategies	
1.	Determine what resources for self-advocacy are currently available.	
2.	Determine any gaps.	
3.	Develop resources to fill the gaps.	
4.	Analyze resident councils and family councils in each LTCO region.	
5.	Increase the number of resident councils and family councils.	
6.	Increase local LTCO representative participation in resident and family councils.	
	Performance Metrics	**SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	SFY 2016: Convene workgroup to determine resources and gaps.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	SFY 2016: Convene workgroup to determine resources and gaps.	
2.	SFY 2017: Create materials to be distributed and a plan for deployment.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	SFY 2017: Create materials to be distributed and a plan for deployment.	
2.	SFY 2018: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy.	**Baseline**
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	SFY 2018: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy.	
2.	SFY 2019: Evaluate success of plan.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	SFY 2019: Evaluate success of plan.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #15 **PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care** **PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options including MFP by September 30, 2019**		
	Strategies	
1.	Provide local LTCO representatives with materials to distribute to residents and families, including brochures and other materials about the ADRC, MFP and HCBS.	
2.	Provide regular outreach to nursing home staff about Community Options and MFP.	
3.	Include in local LTCO representatives' training conferences information about how to use the materials to provide information to residents about other options.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	Coastal AAA provides outreach to nursing home staff monthly through our Options Counseling Program. Our MDSQ Options Counselor conducted 108 outreach events and provided Options Counseling to 162 nursing home residents during this reporting period.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	Coastal AAA provides outreach to nursing home staff monthly through our Options Counseling Program. Our MDSQ Options Counselor conducted 165 outreach events and provided Options Counseling to 233 nursing home residents during this reporting period.
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	Coastal AAA provides outreach to nursing home staff monthly through our Options Counseling Program. Our MDSQ Options Counselor conducted 116 outreach events, provided Options Counseling to 88 nursing home residents and provided Information and Assistance to an addition 34 nursing home residents during this reporting period.
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the	Coastal AAA provides outreach to nursing home staff monthly

AAA #15 **PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care** **PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options including MFP by September 30, 2019**		
	number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	through our Options Counseling Program. Our MDSQ Options Counselor conducted 51 outreach events and provided Options Counseling to144 nursing home residents during this reporting period. Coastal completed 3 presentations to resident councils. (Please note the decrease in the number of outreach events is due to the change in definition of an "allowable outreach event." Options Counseling sessions increased by 63% over previous fiscal year.
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	Coastal AAA provides outreach to nursing home staff monthly through our Options Counseling Program. Our MDSQ Options Counselor conducted 51 outreach events, provided Options Counseling to 144 nursing home residents and provided Information and Assistance to an addition 11 nursing home residents during this reporting period. Coastal completed 3 presentations to resident councils. Options Counseling sessions increased by 63% over previous fiscal year.

ATTACHMENT B – LOCATION OF SERVICES CHARTS

ATTACHMENT B: CHART #1 - <u>Home and Community Based Services (HCBS)</u> Provided in Each County Chart (Include HCBS Individual Services, HCBS In-Home Services, HCBS Nutrition/Wellness, HCBS Caregiver, HCBS Kinship Care Programs, Support Options, Alzheimer's, Evidence Based Programs, Fee-For-Services, Services provided through other Local Funds and Grants, etc.)

Chart #1	Counties ⇨ / Services ⇩	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	Adult Day Care				**x**		**x**			
2.	Mobile Adult Day Care							**x**		
3.	Congregate Meals / Nutrition/ Wellness	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
4.	Home Delivered Meals	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
5.	Homemaker Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
6.	Personal Care Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
7.	Respite Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
8.	HCBS Case Management Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
9.	DHS Coordinated Transportation	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
10.	Care (Hospital) Transitions Services			**x**			**x**			**x**
11.	Assistive Technology Lab	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
12.	Evidenced Based Programs (Chronic Disease Self-Management / DSMP/ Powerful Tools for Caregivers, Matter of Balance/ Thai Chi)	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
13.	RCI REACH			**x**	**x**		**x**	**x**		**x**
14.	Options Counseling	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
15.	Care Consultation	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
16.	Telephone Reassurance						**x**			**x**

ATTACHMENT B – LOCATION OF SERVICES CHARTS Continued…

ATTACHMENT B: Chart #2 – <u>Access Services</u> Provided in Each County Chart

Chart #2	Counties ⇨ / Services ⇩	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh									
1.	GeorgiaCares SHIP Counseling/Education																		
2.	GeorgiaCares SMP Counseling/Education																		
3.	Elderly Legal Assistance Program Counseling/Education	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
4.	Aging & Disability Resource Connection – Counseling/Education/ Assessments/Information & Assistance	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
5.	Money Follows the Person – Options Counseling/ Transitions	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
6.	Services available through Centers for Independent Living (CIL's) including: **Home Modifications**	**x**	**x**	**x**	**x**	**x**	**x**	**x**		**x**									

Chart #2	Counties ⇨ Services ⇩	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh									
7.																			
8.																			
9.																			
10.																			

ATTACHMENT B – LOCATION OF SERVICES CHARTS Continued…

ATTACHMENT B: Chart #3 - <u>Community Care Services Program (CCSP) Services</u> Provided in Each County Chart

Chart #3	Counties ⇨ / Services ⇩	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh									
1.	Adult Day Health	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
2.	Alternative Living Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
3.	Emergency Response System	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
4.	Home Delivered Meals	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
5.	Consumer Directed Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
6.	Personal Support Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
7.	Personal Support Services Extended	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
8.	Respite Care – Out of Home	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
9.	Skilled Nursing Services	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									
10.	Care Coordination	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**									

ATTACHMENT C – COMPLIANCE DOCUMENTS

ATTACHMENT C-1.a – GA DHS DAS REQUEST FOR ADVANCE PAYMENTS AGAINST CONTRACTS LETTER

Georgia Department of Human Services - Division of Aging Services
REQUEST FOR ADVANCE PAYMENT AGAINST CONTRACTS

FROM: **(Type Name of Contracting Entity Here)** Fidelity Bond #: **(Type Fidelity Bond # Here)**

THROUGH: **Jean O'Callaghan, Program Officer, DAS** Bank Account#: **(Type Last 4 Digits ONLY Here)**

OFFICE OF FINANCIAL SERVICES USE ONLY: Contract # _____

TO: Office of Financial Services

It is requested that an advance for the amount(s) listed below in column (A) be made against our contract which begins **(Type Begin Date Here)** and ends **(Type End Date Here)**.

(A) ADVANCE REQUESTED	(B) PURPOSE	(C) BALANCE OWED DHS
	Title III/VII of the Older Americans Act	
	Social Service Block Grant (SSBG)	
	Title V Senior Employment Program	
	Community Care Services Program (CCSP)	
	State Alzheimer's Program	
	State Community Based Services (CBS)	
	State Health Insurance Program/GACARES	
TOTAL:		TOTAL:

We currently have the amount(s) listed in column (C) above in DHS advance funds in our possession which is un-liquidated against valid expenditure reports. **[NOTE: If the last advance granted has not been repaid entirely, the current balance owed to DHS should be listed in column C above.]**

It is understood that this/these advance funds will be liquidated against valid expenditure reports before the end of the contract.

_____	Signed: _____	**(Type Name and Title Here)**
Date	Contractor Administrator/Director	
_____	Recommended Approval/Disapproval	_____
Date		Program Officer, DAS
_____	Recommended Approval/Disapproval	_____
Date		Division Director, DAS
_____	Approval/Disapproval	_____
Date		Director, DHS Office of Financial Services

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.b – GA DHS DAS REQUEST FOR ADVANCE LETTER

GEORGIA DEPARTMENT OF HUMAN SERVICES

Division of Aging Services

Date:

TO: Office of Financial Services Department of Human Services

FROM: _____ Contract Number 427 _____
Division/Office Director Control Number _____

SUBJECT: Statement of Need for a Contractor
Advance of Funds

Name of Program(s) ☐ Title III/VII ☐ Long-term care Ombudsman ☐ Social Service Block Grant
☐ Title V Employment ☐ Community Care ☐ Alzheimer's ☐ State Community Based Services
☐ State Health Insurance Program (SHIP)

Name of Contractor: [Type Here]

Address: [Type Here]

1. What is the specific financial status of the contractor?
2. If the contractor currently has any DHS advance in its possession, when was it received and when will it be repaid?
3. What is the minimum advance dollar amount necessary to support contractor's operations for this contract?
4. When will the contractor no longer need an advance and begin performing contract on a reimbursement basis?
5. Narrative justification for this advance and why some other contractor could not perform the requirements of this contract without an advance of funds from DHS.
6. Monthly advance repayment schedule, if approved.

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.c – REQUEST FOR ADVANCE WORKSHEET

Fund Source	Federal/State/Local Funds*	Total Advance (Col. B/12)
Title III/VII of the Older Americans Act		
Social Service Block Grant (SSBG)		
Title V Senior Employment Program		
Community Care Services Program (CCSP)		
State Alzheimer's Program		
State Community Based Services (CBS)		
State Health Insurance Program/GACARES		
TOTAL		

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.d – LETTER OF BOND COVERAGE

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-2 – STANDARD ASSURANCES

STANDARD ASSURANCES - OLDER AMERICANS ACT (OAA)
Public Law 89-73, 42 U.S.C.A. § 3001, et seq., as amended

I) ORGANIZATIONAL ASSURANCES

1. SEPARATE ORGANIZATIONAL UNIT

If the Area Agency on Aging has responsibilities which go beyond programs for the elderly, a separate organizational unit within the agency has been created which functions only for the purposes of serving as the Area Agency on Aging.

2. FULL TIME DIRECTOR

The Area Agency or the separate organizational unit which functions only for the purposes of serving as the Area Agency on Aging is headed by an individual qualified by education or experience, working full-time solely on Area Agency on Aging functions and Area Plan management.

II) AREA AGENCY MANAGEMENT COMPLIANCE ASSURANCES

3. EQUAL EMPLOYMENT OPPORTUNITY (5CFR Part 900, Subpart F)

The Area Agency assures fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

4. EMERGENCY MANAGEMENT PLAN

The Area Agency has assigned primary responsibility for Emergency Management planning to a staff member; the Area Emergency Management Plan which was developed in accordance with the Georgia Department of Human Resources Division of Aging Services (now the Georgia Department of Human Services, and hereafter Division of Aging Services) memorandum of February 9, 1979 shall be reviewed at least annually and is revised as necessary. The Area Agency also assures cooperation subject to client need in the use of any facility, equipment, or resources owned or operated by the Department of Human Services which may be required in the event of a declared emergency or disaster.

As in Sec. 306 (a) (16) or (17), the Area Agency shall include information detailing how the Area Agency on aging will coordinate activities, and develop long-range emergency response plans with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for relief service delivery.

5. DIRECT PROVISION OF SOCIAL SERVICES

No Title III supportive services, nutrition services, or in-home services are being directly provided by the Area Agency except where provision of such services by the Area Agency has been determined by the Division of Aging Services to be necessary in assuring an adequate supply of such services; or where services are directly related to the AAA administrative functions; or where services of comparable quality can be provided more economically by the Area Agency.

6. REVIEW BY ADVISORY COUNCIL

The Area Agency has provided the Area Agency Advisory Council the opportunity to review and comment on the Area Plan and operations conducted under the plan.

7. ATTENDANCE AT STATE TRAINING

The Area Agency assures that it will send appropriate staff to those training sessions required by the Division of Aging Services.

8. PROPOSAL FOR PROGRAM DEVELOPMENT AND COORDINATION

The Area Agency has submitted the details of its proposals to pay for program development and coordination as a cost of supportive services to the general public (including government officials, and the aging services network) for review and comment. The Area Agency has budgeted its total allotment for Area Plan Administration before budgeting Title III-B funds for Program Development in accordance with 45 CFR 1321.17(14).

9. COMPETITIVE PROCESS FOR NUTRITION PROVIDERS, SUPPORTIVE SERVICES PROVIDERS, AND FOOD VENDORS

a) Nutrition providers and supportive service providers will be selected through competitive negotiations or a Request for Proposal process. Documentation will be maintained in the Area Agency files.

b) Nutrition service providers who have a central kitchen or who prepare food on- site must obtain all food and supplies through appropriate procurement procedures, as specified by the Division of Aging Services.

c) Food vendors will be selected through a competitive sealed bid process.

d) Nutrition service providers who have a central kitchen or who prepare meals on-site must develop a food service proposal.

e) Copies of all Requests for Proposals and bid specifications will be maintained at the Area Agency for review.

10. REPORTING

The Area Agency assures that it will maintain required data on the services included in the Area Plan and report such data to the Division of Aging Services in the form and format requested.

11. NO CONFLICT OF INTEREST

No officer, employee, or other representative of the Area Agency on Aging is subject to a conflict of interest prohibited under this Act; and mechanisms are in place at the Area Agency on Aging to indentify and remove conflicts of interest prohibited under this Act.

III) SERVICE PROVISION ASSURANCES

12. MEANS TEST

No Title III service provider uses a means test to deny or limit receipt of Title III services under the Area Plan.

13. EQUAL EMPLOYMENT OPPORTUNITY BY SERVICE PROVIDERS

The Area Agency assures that service providers provide fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

14. STANDARDS/GUIDELINES/POLICIES AND PROCEDURES

The Area Agency and all service providers will comply with all applicable Georgia Department of Human Services Division of Aging Services standards, guidelines, policies, and procedures.

NOTE: No additional waiver of the Multi-Purpose Senior Center (MPSC) Standards is necessary IF the Area Agency has previously obtained such a waiver AND there have been no changes since the submission of the waiver request.

15. SPECIAL MEALS

Each nutrition program funded under the Area Plan is providing special meals, where feasible and appropriate, to meet the particular dietary needs, arising from the health requirements, religious requirements, or ethnic backgrounds of eligible individuals.

16. CONTRIBUTIONS

Older persons are provided an opportunity to voluntarily contribute to part or all of the cost of Title III services received under the Area Plan, in accordance with procedures established by the Division of Aging Services. Title III services are not denied based on failure to contribute.

The area agency on aging shall ensure that each service provider will-

(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;

(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;

(D) establish appropriate procedures to safeguard and account for all contributions; and

(E) use all collected contributions to expand the service for which the contributions were given and to supplement (not supplant) funds received under this Act.

Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act if the method of solicitation is not coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.

17. PERSONNEL POLICIES

Written personnel policies affecting Area Agency and service provider staff have been developed to include, but are not limited to, written job descriptions for each position; evaluation of job performance; annual leave; sick leave; holiday schedules; normal working hours; and compensatory time.

18. COORDINATION WITH TITLE V NATIONAL SPONSORS

The Area Agency will meet at least annually with the representatives of Title V Older American Community Service Employment Program (formerly SCSEP) sponsors operating within their Planning and Service Areas (PSAs) to discuss equitable distribution of enrollee positions within the PSA and coordinate activities as appropriate.

19. PREFERENCE IN PROVIDING SERVICES

The Area Agency on Aging provides assurance that preference will be given to services to older individuals with the greatest economic need and older individuals with the greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the Area Plan. [Section 305 (a) (2) (E)]

IV) TITLE III, PART A ASSURANCES

The Area Agency on Aging assures that it shall --

20. Sec. 306(a)(2) - provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the Area Agency on Aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

21. Sec. 306(a) (4) (A) (i) (I) - provide assurances that the Area Agency on Aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub clause (I);

22. Sec. 306(a)(4)(A)(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

23. Sec. 306(a)(4)(A)(iii) - With respect to the fiscal year preceding the fiscal year for which such plan is prepared, the Area Agency on Aging shall—

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a) (4) (A) (i).

24. Sec. 306(a)(4)(B)(i) - provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance;

25. Sec. 306(a)(4)(C) - provide assurance that the Area Agency on Aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

26. Sec. 306(a)(5) provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

27. Sec. 306(a)(6)(A) - take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

28. Sec. 306(a) (6) (B) -serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals

29. Sec. 306(a) (6) (C) (i) – enter, where possible, into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 675(c)(3) of the Community Services Block Grant Act (42 U.S.C. 9904(c)(3)); and

30. Sec. 306(a) (6) (C) (iii) - make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have

experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

31. Sec. 306(a)(6)(D) – establish and maintain an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

32. Sec. 306(a)(6)(F) – The Area Agency on Aging will in coordination with the State Agency on Aging (Georgia Department of Human Services Division of Aging Services) and the State agency responsible for mental health services (Georgia Department of Behavioral Health and Developmental Disabilities), increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the Area Agency on Aging with the mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

33. Sec. 306(a)(7) - provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by –

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better –
(i) respond to the needs and preferences of older individuals and family caregivers;
(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidenced-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information related to –

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources.

34. Sec. 306(a) (8) that case management services provided under this title through the area agency on aging will -

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that -

(i) gives each older individual seeking service under this subchapter a list of agencies that provide similar services within the jurisdiction of the area agency on Aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirement described in clauses (i) through (iii); and

(v) is not located, does not provide, and does not have a direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with, an entity that provides, services other than case management services under this title.

35. ~~Sec. 306(a)(9) - provide assurances that the Area Agency on Aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this subchapter.~~

36. Sec. 306(a) (10) establish a grievance procedure for older individuals who are dissatisfied with or denied services under this subchapter;

37. Sec. 306 (a) (11) – provide information and assurances by the Area Agency on Aging concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the Area Agency on Aging will make services under the area plan available; to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

38. Sec**.** 306 (a**)**(13)(A) - provide assurances that the Area Agency on Aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

39. Sec. 306 (a) (13) (B) - provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State Agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

40. Sec. 306(a)(13)(C) - provide assurances that the Area Agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

41. Sec. 306(a)(13)(D) - provide assurances that the Area Agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

42. Sec. 306(a**)**(13)(E) - shall provide assurances that the Area Agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

43. Sec. 306(a**)** (14) -. provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

44. Sec. 307(a)(15)(A) - provide assurances that funds received under this title will be used - to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

45. Sec. 307(a)(15)(B) – provide assurances that funds received under this title will be used in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212 (42 U.S.C.A. § 3020c);

46. Sec. 306(a) (16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

47. Conduct annual evaluations of, and *public hearings* on, activities carried out under the area plan and an annual evaluation of the effectiveness of outreach conducted under paragraph (5) (B);

48. Furnish appropriate technical assistance and timely information in a timely manner, to providers of supportive services, nutrition services, or multipurpose senior centers in the planning and service area covered by the area plan;

49. Sec. 306 (a)(6)(C)(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

50. Develop and publish methods by which priority of services is determined, particularly with respect to the delivery of services under paragraph (2);

51. Establish effective and efficient procedures for coordination of -

(I) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

52. Identify the public and private nonprofit entities involved in the prevention, identification, and treatment of the abuse, neglect, and exploitation of older individuals, and based on such identification, determine the extent to which the need for appropriate services for such individuals is unmet;

53. Compile available information on institutions of higher education in the planning and service area regarding-

(I) the courses of study offered to older individuals by such institutions; and

(II) the policies of such institutions with respect to the enrollment of older individuals with little or no payment tuition, on a space available basis, or on another special basis;

(III) include in such compilation such related supplementary information as may be necessary; and

(IV) based on the results of such compilation, make a summary of such information available to older individuals at multipurpose senior centers, congregate nutrition sites, and other appropriate places;

54. Sec. 306 (a) (6) (Q) enter into voluntary arrangements with nonprofit entities (including public and private housing authorities and organizations) that provide housing (such as housing under section 202 of the Housing Act of 1959 (12 U.S.C. 1701Q) to older individuals, to provide-

(I) leadership and coordination in the development, provision, and expansion of adequate housing, supportive services, referrals, and living arrangements for older individuals; and

(ii) advance notification and non-financial assistance to older individuals who are subject to eviction from such housing;

55. List the telephone number of the agency in such telephone directory that is published, by the provider of local telephone service, for residents in any geographical area that lies in whole or in part in the service and planning area served by the agency -

(I) under the name "Area Agency on Aging";

(ii) in the unclassified section of the directory; and

(iii) to the extent possible, in the classified section of the directory, under a subject heading designated by the Commissioner by regulation; and

56. Identify the needs of older individuals and describe methods the area agency on aging will use to coordinate planning and delivery of transportation services (including the purchase of vehicles) to assist older individuals, including those with special needs, in the area;

57. Provide assurances that any amount received under part E will be expended in accordance with such part;

58. Provide assurances that any amount received under part F will be expended in accordance with such part;

59. Provide assurances that any amount received under part G will be expended in accordance with such part;

60. In the discretion of the area agency on aging, provide for an area volunteer services coordinator, who shall -

(A) encourage, and enlist the services of, local volunteer groups to provide assistance and services appropriate to the unique needs of older individuals within the planning and services area; and

(B) encourage, organize, and promote the use of older individuals as volunteers to local communities within the area; and

(C) promote the recognition of the contribution made by volunteers to programs administered under the area plan;

(D) assure that the activities conform with -

(i) the responsibilities of the area agency on aging, as set forth in this subsection; and

(ii) the laws, regulations, and policies of the State served by the area agency on aging;

61. Projects in the planning and service area will reasonably accommodate participants as described in the Act'

62. Before an Area Agency on Aging requests a waiver under paragraph (1) of this subsection, the Area Agency shall conduct a timely public hearing in accordance with the provisions of this paragraph. The Area Agency on Aging requesting a waiver shall notify all interested parties in the area of public hearing and furnish the interested parties with an opportunity to testify.

63. The Area Agency on Aging shall prepare a record of the public hearing conducted pursuant to Section 306(b)(2)(A) and shall furnish the record of public hearing with the request for a waiver made to the State under paragraph (1).

64. Provide that the Area Agency on Aging will facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who -- --

(A) Reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) Are patients in hospitals and are at risk of prolonged institutionalization; or
(C) Are patients of long-term care facilities, but who can return to their homes in community-based options are provided to them.

65. Provide that the Area Agency on Aging will facilitate coordination of community-based, long-term care services designed to enable older individuals to remain in their homes, by means including –

(A) development of case management services as a component of the long-term care services, consistent with the requirements of paragraph (64);
(B) involvement of long-term care providers in the coordination of such services; and
(C) increasing community awareness of and involvement in addressing the needs of residents of long-term care facilities;

66. Provide that case management services provided under this title through the area agency on aging will--
(A) not duplicate case management services provided through other Federal and State programs;
(B) be coordinated with services described in subparagraph (A); and
(C) be provided by a public agency or a nonprofit private agency that--
(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;
(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

67. Provide that the Area Agency on Aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in Section 203(b) within the planning and service area.

68. Provide that the Area Agency on Aging, with respect to the needs of older individuals with severe disabilities, will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the Sate agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals and disabilities.

V) TITLE VII/LONG-TERM CARE OMBUDSMAN PROGRAM ASSURANCES

69. The Area Agency assures the provision of long-term care ombudsman services that fulfill the mandate for sub state ombudsman programs as specified in Title III and Title VII of the Older Americans Act and in state law (O.C.G.A Section 31-8-50, et seq.).

70. The Area Agency provides assurance that, in carrying out programs with respect to the prevention of elder abuse, neglect, and exploitation under the Older Americans Act, it will expend from the funds appropriated under Section 702 (b) of the Older Americans Act not less than the total amount allocated by the Division of Aging services for that fund source.

71. Provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under Section 307(a)(9), will expend not less than the total amount of funds appropriated under the Older Americans Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

VI) TITLE VII/LEGAL ASSISTANCE ASSURANCES

72. Sec. 307(11) (A) provide assurances that the Area Agency on Aging will –
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

Signature:
Dionne Lovett
Area Agency on Aging Director

Signature:
Reggie Loper
Coastal Regional Commission Chair

eipt of funds under division (A) will be subject to
gal Services Corporation Act (other than
ance under such Act and governing membership of
istant Secretary; and

authorized under this title, including groups
pro bono and reduced fee basis.

legal assistance furnished under the Area Plan will
ned with funds from sources other than this Act and
assistance for older individuals.

e priority to legal assistance related to income,
es, defense of guardianship, abuse, neglect, and

gency on Aging is in compliance and will

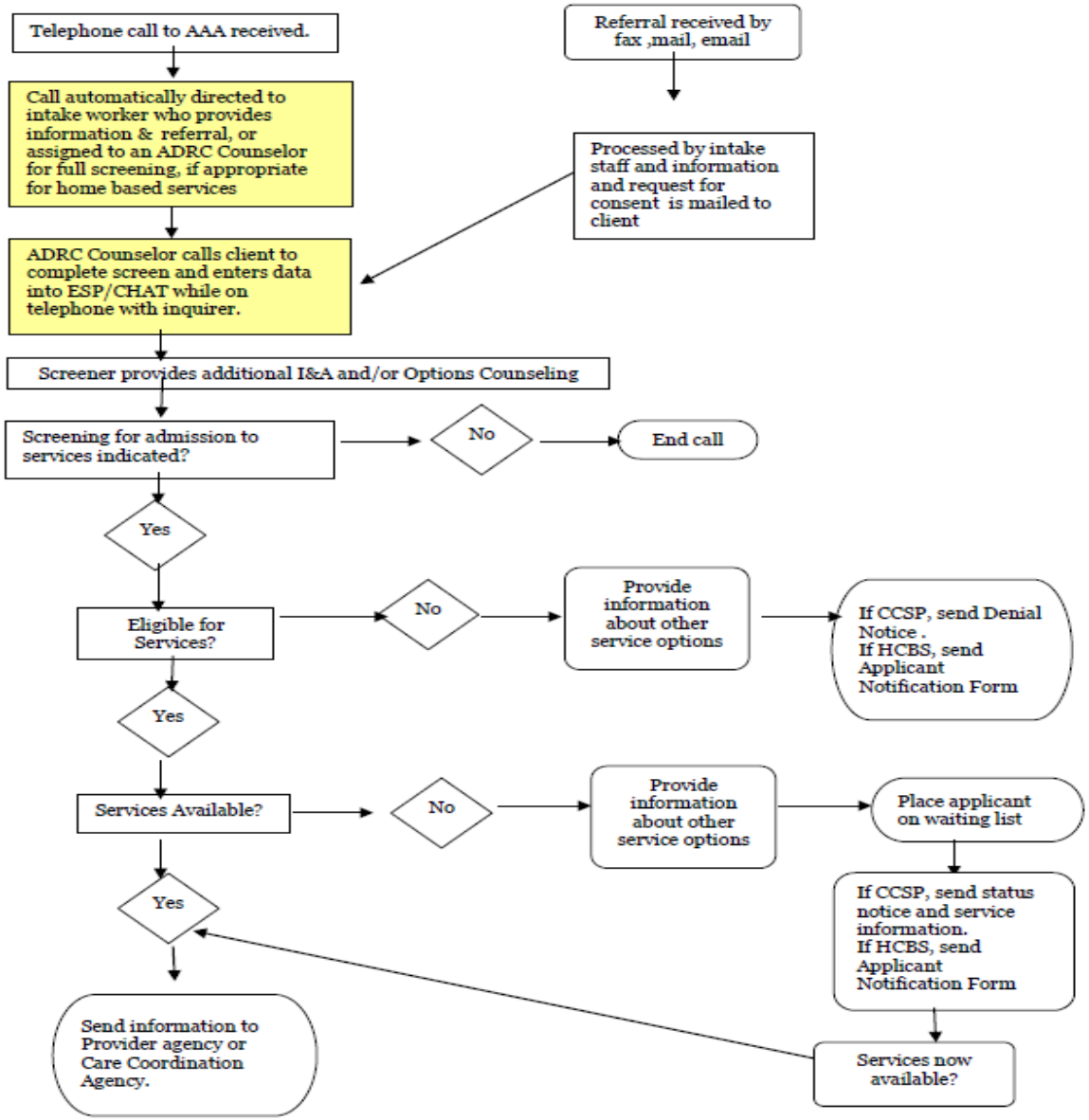
Signature: _____
Dionne Lovett
Area Agency on Aging Director

Date: 02/28/2019

Signature: _____
Reggie Loper
Coastal Regional Commission Chair

Date: 02/28/2019

Coastal Georgia Area Agency on Aging
Information & Assistance ADRC Model



**Note: Intake worker provides I&A and Options Counseling during initial contact. If no additional information is needed, no referral is made for follow-up or screening.*

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-4 – BOARD RESOLUTION

Resolution

Whereas, Federal law and the Georgia Department of Human Services/Division of Aging Services rules require each Area Agency on Aging to prepare *an Area Plan for Aging Services for FY 2017-2020*; and

Whereas, the document known as the *Area Plan for Aging Services of Coastal Georgia FY 2017-2020* was submitted to the Coastal Area Agency on Aging Advisory Council for review and comment on January 22, 2019; and

Whereas, the Coastal Area Agency on Aging Advisory Council unanimously approved the *Area Plan for Aging Services of Coastal Georgia for FY 2017-2020* on January 22, 2019; and

Whereas, the Georgia Department of Human Services/Division of Aging Services requires that the document be presented to the CRC Council for final adoption;

Now therefore, be it resolved, that the Coastal Regional Commission Council hereby adopts the *Area Plan for Aging Services FY 2017-2020 of Coastal Georgia.*

Adopted this 13th day of February, 2019.

Coastal Regional Commission of Georgia

By: Reggie Loper
Reggie Loper, Chairman

Attest:

By:
Allen Burns, Executive Director

ATTACHMENT D – REQUIRED PLANS

No Required Plans requested to be included in the SFY 2019 Area Plan Submittal.

Do not delete this Page.

Older Americans Act (OAA) Federal Allocation Match Analysis Worksheet

Enter Name of AAA:	Coastal Region AAA
State Fiscal Year:	SFY 2020

Indicate the Applicable Budget Submission:	_X_ SFY 2020 Planning Allocation Area Plan Update
	_____ SFY 2020-____ Allocation Issuance (AI)
	_____ SFY 2020-____ AI AAA Initiated Budget Revision

	Original DAS Allocation by Part	Requested Shift by Part	Revised Allocation by Part	% Budgeted Federal Dollars Allocated	Total Budget to be Matched
Title III A Admin from Title III B, C & E	$203,765	$0	$203,765	75%	$271,687
Title III B Supportive Svcs	$501,019	$264,351	$765,370	85%	$900,435
Title III C-1 Congregate Meals	$858,026	-$82,029	$775,997	85%	$912,938
Title III C-2 Home Delivered Meals	$447,984	$136,565	$584,549	85%	$687,705
Title III D Health Promotion	$42,858	$0	$42,858	85%	$50,421
Title III D Medications Management	$0	$0	$0	85%	$0
Title III E Family Caregiver Support	$187,764	$0	$187,764	75%	$250,352
	$0	$0	$0	85%	$0
Total	$2,241,416	$318,887	**$2,560,303**		**$3,073,538**

	Budget to be Matched	Match Requirement	Total Match Required	State Match	Local Match Required
Title III A Admin from Title III B, C & E	$271,687	25%	$67,922	N/A	$67,922
Title III B Supportive Svcs	$900,435	15%	$135,065	$45,022	$90,044
Title III C-1 Congregate Meals	$912,938	15%	$136,941	$45,647	$91,294
Title III C-2 Home Delivered Meals	$687,705	15%	$103,156	$34,385	$68,771
Title III D Health Promotion	$50,421	15%	$7,563	$2,521	$5,042
Title III D Medications Management	$0	15%	$0	$0	$0
Title III E Family Caregiver Support	$250,352	25%	$62,588	$37,553	$25,035
	$0	15%	$0	$0	$0
Total	**$3,073,538**		$513,235	$165,128	$348,108

MAN 5600, Appendix D
Revised: December 2017

2/27/2019
1:38 PM

Provider Services List

Agency: Coastal Georgia Region AAA

Start Date: 07/01/2018

End Date: 06/30/2019

Parent Provider: Altamaha Home Care, Inc. Coastal GA [Parent]

Contact	Address	Programs	Services
Name: Lisa Deen Phone: (912)367-1046 Fax: (912)366-0068 Email: lisaahc@accessatc.net	52 North Oak Street Baxley, GA 31513	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker
			Personal Care

Service Provider: Altamaha Home Care, Inc. Coastal GA [Parent]

Contact	Address	Programs	Services
Name: Lisa Deen Phone: (912)367-1046 Fax: (912)366-0068 Email: lisaahc@accessatc.net	52 North Oak Street Baxley, GA 31513	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker
			Personal Care

Parent Provider: Bryan County Board of Commissioners [Parent]

Contact	Address	Programs	Services
Name: Ben Taylor Phone: (912)653-3899 Fax: (912)653-4691 Email: btaylor@bryan-county.org	Post Office Box 430, Pembroke, GA 31321	HCBS - HCBS Services	Senior Recreation
		HCBS - Senior Centers	Congregate Meals
			Exercise/Physical Fitness - Group
			Health Promotion/Disease Prevention
			Nutrition Education
			Outreach
			Senior Recreation

Service Provider: Pembroke Senior Citizens Center

Contact	Address	Programs	Services
Name: Bernadette Smokes Phone: (912)653-4480 Fax: (912)653-5794 Email:	24 West Bacon Street Pembroke, GA 31321	HCBS - Senior Centers	Congregate Meals
			Exercise/Physical Fitness - Group
			Health Promotion/Disease Prevention
			Nutrition Education
			Outreach

Name: Bernadette Smokes Phone: (912)653-4480 Fax: (912)653-5794 Email:	24 West Bacon Street Pembroke, GA 31321	HCBS - Senior Centers	Senior Recreation

Service Provider: **Richmond Hill Senior Citizens Center**

Contact	Address	Programs	Services
Name: TBN Phone: (912)756-2783 Fax: (912)459-0201 Email: sshuman@bryan-county.org	9930 Ford Ave Richmond Hill, Georgia 31324	HCBS - HCBS Services	Senior Recreation
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Outreach Senior Recreation

Parent Provider: **Bulloch County Senior Center**

Contact	Address	Programs	Services
Name: Alex Smith Phone: (912)489-1604 Fax: (912)764-3210 Email: alsmith@concertedservices.org	515 Denmark St Suite 400 Statesboro, GA 30458	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Bulloch County Senior Center**

Contact	Address	Programs	Services
Name: Alex Smith Phone: (912)489-1604 Fax: (912)764-3210 Email: alsmith@concertedservices.org	515 Denmark St Suite 400 Statesboro, GA 30458	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **Camden County Commission [Parent]**

Contact	Address	Programs	Services
Name: Darlene Bell Phone: (912)729-1945 Fax: (912)673-6957 Email: seniorcenterpsa@tds.net	1501 Georgia Avenue Woodbine, GA 31569	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Camden County Senior Center**

Contact	Address	Programs	Services
Name: Darlene Bell Phone: (912)729-1945 Fax: (912)673-6957 Email: seniorcenterpsa@tds.net	1501 Georgia Avenue Woodbine, GA 31569	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **Camden County Senior Center**

Contact	Address	Programs	Services
Name: Darlene Bell Phone: (912)729-1945 Fax: (912)673-6957 Email: seniorcenterpsa@tds.net	1501 Georgia Avenue Woodbine, GA 31569	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Camden County Senior Center**

Contact	Address	Programs	Services
Name: Darlene Bell Phone: (912)729-1945 Fax: (912)673-6957 Email: seniorcenterpsa@tds.net	1501 Georgia Avenue Woodbine, GA 31569	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **City of Brunswick [Parent]**

Contact	Address	Programs	Services
Name: James Drumm Phone: (912)267-5530 Fax: (912)267-5542 Email: jdrumm@cityofbrunswick-ga.gov	601 Gloucester Street Brunswick, GA 31520	HCBS - HCBS Services	Adult Day Care
		HCBS - Senior Centers	Congregate Meals

Service Provider: **Brunswick Multi-Purpose Center**

Contact	Address	Programs	Services
Name: Darlene Wymes Phone: (912)267-5520 Fax: (912)267-5591 Email: drwymes@brunswick-ga.gov	2007 'I' Street Brunswick, GA 31520	HCBS - HCBS Services	Adult Day Care
		HCBS - Senior Centers	Congregate Meals

Service Provider: **City of Brunswick [Parent]**

Contact	Address	Programs	Services
Name: James Drumm Phone: (912)267-5530 Fax: (912)267-5542 Email: jdrumm@cityofbrunswick-ga.gov	601 Gloucester Street Brunswick, GA 31520	HCBS - Senior Centers	Congregate Meals

Parent Provider: **City of Savannah - Leisure Services [Parent]**

Contact	Address	Programs	Services
Name: Necol Fuller Phone: (912)351-3841 Fax: (912)351-3423 Email: nfuller@savannahga.gov	Two East Bay Street Savannah, GA 31401	HCBS - HCBS Services	Adult Day Care
			Senior Recreation
		HCBS - Senior Centers	Congregate Meals
			Exercise/Physical Fitness - Group
			Exercise/Physical Fitness - Individual
			Health Promotion/Disease Prevention
			Nutrition Education
			Outreach
			Senior Recreation

Service Provider: **Carver Heights Golden Age Center**

Contact	Address	Programs	Services
Name: Gracie Brown Phone: (912)650-7816 Fax: (912)650-7816 Email:	905 Collatt Avenue Savannah, GA 31415	HCBS - Senior Centers	Congregate Meals

Service Provider: **Cloverdale Senior Center**

Contact	Address	Programs	Services
Name: Linda Johnson Phone: (912)236-1244 Fax: Email:	1919 Cynthia Street Savannah, GA 31405	HCBS - Senior Centers	Congregate Meals

Service Provider: **Crusader Golden Age Center**

Contact	Address	Programs	Services
Name: Rose Haynes Phone: (912)921-5743 Fax: (912)921-2103 Email:	81 Coffee Villa Road Savannah, GA 31419	HCBS - Senior Centers	Congregate Meals

Service Provider: **Eastside Golden Age Center**

Contact	Address	Programs	Services
Name: Tanya Futch Phone: (912)651-4325 Fax: Email: tfutch@savannahga.gov	409 Goebel Street Savannah, GA 31404	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Outreach Senior Recreation

Service Provider: **Hudson Hill Golden Age Center**

Contact	Address	Programs	Services
Name: Tina Hicks Phone: (912)650-7815 Fax: Email:	2227 Hudson Hill Savannah, GA 31415	HCBS - Senior Centers	Congregate Meals

Service Provider: **Liberty City Golden Age Center**

Contact	Address	Programs	Services
Name: Rosalyn Wright Phone: (912)650-7804 Fax: (912)652-3804 Email:	1401 Mills B. Lane Boulevard Savannah, GA 31405	HCBS - Senior Centers	Congregate Meals

Service Provider: **Mary B. Flournoy Golden Age Center**

Contact	Address	Programs	Services
Name: Debora Anthony Phone: (912)651-2192 Fax: Email: danthony@Savannahga.gov	1001 W. 39th Street Savannah, GA 31415	HCBS - HCBS Services	Senior Recreation

Name: Debora Anthony Phone: (912)651-2192 Fax: Email: danthony@Savannahga.gov	1001 W. 39th Street Savannah, GA 31415	HCBS - Senior Centers	Congregate Meals

Service Provider: **Moses Jackson Golden Age Center**

Contact	Address	Programs	Services
Name: Rebecca Middleton Phone: (912)651-6785 Fax: Email: rjohnson@savannahga.gov	1410 Richards Street Savannah, GA 31415	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Exercise/Physical Fitness - Individual Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Savannah Adult Day Care Center**

Contact	Address	Programs	Services
Name: Robin Mervin Phone: (912)651-6774 Fax: (912)652-3830 Email: Ledwell86@yahoo.com	3025 Bull Street Savannah, GA 31405	HCBS - HCBS Services	Adult Day Care

Service Provider: **Stillwell Towers Golden Age Center**

Contact	Address	Programs	Services
Name: Alfredia Thomas Phone: (912)351-3855 Fax: Email:	5100 Waters Avenue Savannah, GA 31404	HCBS - Senior Centers	Congregate Meals

Service Provider: **Tatumville Golden Age Center**

Contact	Address	Programs	Services
Name: Shvokeia Watson Phone: (912)691-6289 Fax: Email:	333 Coleman Street Savannah, GA 31405	HCBS - Senior Centers	Congregate Meals

Service Provider: **The Veranda Golden Age Center**

Contact	Address	Programs	Services
Name: Juanita Scott Phone: (912)651-2000 Fax: Email: jscott@savannahga.gov	1414 East Anderson Street Savannah, GA 31404	HCBS - Senior Centers	Congregate Meals

Service Provider: **Windsor Forest Golden Age Center**

Contact	Address	Programs	Services
Name: Laura Brown Phone: (912)921-2104 Fax: Email:	308 Briarcliff Circle Savannah, GA 31419	HCBS - Senior Centers	Congregate Meals

Service Provider: **Woodville Golden Age Center**

Contact	Address	Programs	Services
Name: Barbara Moon Phone: (912)965-2373 Fax: Email:	129 Darling Street Savannah, GA 31405	HCBS - Senior Centers	Congregate Meals

Parent Provider: **Coastal Georgia Region AAA**

Contact	Address	Programs	Services
Name: Dionne Lovett Phone: (912)437-0800 Fax: (912)437-0840 Email: dlovett@crc.ga.gov	1181 Coastal Drive SW Darien, GA 31305	HCBS - Caregiver Services	REACH
		HCBS - Case Management	Case Management
		HCBS - Evidence Based Services	CDSME - CDSMP
		HCBS - HCBS Services	Material Aid - Individual

Service Provider: **Coastal Georgia Region AAA**

Contact	Address	Programs	Services
Name: Dionne Lovett Phone: (912)437-0800 Fax: (912)437-0840 Email: dlovett@crc.ga.gov	1181 Coastal Drive SW Darien, GA 31305	HCBS - Case Management	Case Management

Service Provider: **Coastal Regional Commission**

Contact	Address	Programs	Services
Name: Dionne Lovett Phone: (912)437-0840 Fax: (912)437-0801 Email: dlovett@crc.ga.gov	1181 Coastal Drive SW Darien, GA 31305	HCBS - Caregiver Services	REACH
		HCBS - Case Management	Case Management
		HCBS - Evidence Based Services	CDSME - CDSMP
		HCBS - HCBS Services	Material Aid - Individual

Parent Provider: **Effingham County Board of Commissioners [Parent]**

Contact	Address	Programs	Services
Name: Margaret Moore Phone: (912)754-2138 Fax: (912)754-2152 Email: mmoore@effinghamcounty.org	Post Office Box 307 Springfield, GA 31329	HCBS - Senior Centers	Congregate Meals

Service Provider: **Effingham County Senior Citizens Center**

Contact	Address	Programs	Services
Name: Margaret Moore Phone: (912)754-2138 Fax: (912)754-2152 Email: mmoore@effinghamcounty.org	601 North Laurel Street Springfield, GA 31329	HCBS - Senior Centers	Congregate Meals

Parent Provider: **Effingham County Senior Citizens Center**

Contact	Address	Programs	Services
Name: Margaret Moore Phone: (912)754-2138 Fax: (912)754-2152 Email: mmoore@effinghamcounty.org	601 North Laurel Street Springfield, GA 31329	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Effingham County Senior Citizens Center**

Contact	Address	Programs	Services
Name: Margaret Moore Phone: (912)754-2138 Fax: (912)754-2152 Email: mmoore@effinghamcounty.org	601 North Laurel Street Springfield, GA 31329	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **Heavenly Divine Blessing dba Big Mama's Kitchen [Parent]**

Contact	Address	Programs	Services
Name: Kevin Blue Phone: (912)673-6418 Fax: (912)673-6865 Email: dawneggleston@hotmail.com	5524 Hwy 17 North Kingsland, GA 31548	HCBS - Nutrition Services	Home Delivered Meals

Service Provider: **Heavenly Divine Blessings - Camden County**

Contact	Address	Programs	Services

Name: Kevin Blue Phone: (912)673-6418 Fax: (912)673-6865 Email:	5524 US Hwy 17 North Kingsland, GA 31548	HCBS - Nutrition Services	Home Delivered Meals

Parent Provider: **Long County Board of Commissioners [Parent]**

Contact	Address	Programs	Services
Name: Mary Ann Odum Phone: (912)545-2143 Fax: (912)545-2150 Email:	Highway 57, Ludowici, GA 31316	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Long County Senior Citizens Center**

Contact	Address	Programs	Services
Name: Kelli Mock Phone: (912)545-2435 Fax: (912)545-3435 Email: kmock@concertedservices.org	15 Thorton Drive Ludowici, GA 31316	HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **McIntosh County Commissioners [Parent]**

Contact	Address	Programs	Services
Name: Patrick Zoucks Phone: (912)437-6671 Fax: (912)437-6416 Email: patrick.zoucks@mcintoshcounty-ga.gov	310 North Way Darien, GA 31305	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Outreach Senior Recreation

Service Provider: **CAA McIntosh County Senior Center**

Contact	Address	Programs	Services

Contact	Address	Programs	Services
Name: Linda Slade Phone: (912)832-2444 Fax: Email: lslade@coastalgacaa.org	1009 Eulonia Park Road, NW Townsend, GA 31331	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Outreach Senior Recreation

Parent Provider: **Nightingale Services, Inc. - HCBS - Coastal GA AAA**

Contact	Address	Programs	Services
Name: Ryan S. Trettien Phone: (912)355-6472 Fax: (912)691-4716 Email: rtrettien@help-1.com	9100 White Bluff Road Savannah, GA 31406	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker Personal Care

Service Provider: **Nightingale Services, Inc. - HCBS - Coastal GA AAA**

Contact	Address	Programs	Services
Name: Ryan S. Trettien Phone: (912)355-6472 Fax: (912)691-4716 Email: rtrettien@help-1.com	9100 White Bluff Road Savannah, GA 31406	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker Personal Care

Parent Provider: **PurFoods, LLC [Parent]**

Contact	Address	Programs	Services
Name: Nathan Jensen Phone: (866)716-3257 Fax: (515)266-6120 Email: Nathan.jensen@momsmeals.com	3120 SE 72nd Street Ankeny, IA 50021	HCBS - Nutrition Services	Home Delivered Meals

Service Provider: **PurFoods, LLC [Parent]**

Contact	Address	Programs	Services
Name: Nathan Jensen Phone: (866)716-3257 Fax: (515)266-6120 Email: Nathan.jensen@momsmeals.com	3120 SE 72nd Street Ankeny, IA 50021	HCBS - Nutrition Services	Home Delivered Meals

Parent Provider: **ResCare HomeCare – HCBS – Coastal GA AAA**

Contact	Address	Programs	Services

Name: Tracy Castellaw Phone: (912)685-4221 Fax: (912)685-4223 Email: tcastellaw@rescare.com	38 S E Broad Street Metter, GA 30439	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker Personal Care

Service Provider: **ResCare HomeCare – HCBS – Coastal GA AAA**

Contact	Address	Programs	Services
Name: Tracy Castellaw Phone: (912)685-4221 Fax: (912)685-4223 Email: tcastellaw@rescare.com	38 S E Broad Street Metter, GA 30439	HCBS - Caregiver Services	Respite Care In-Home
		HCBS - In-Home Services	Homemaker Personal Care

Parent Provider: **Senior Citizens, Inc. (Chatham County) [Parent]**

Contact	Address	Programs	Services
Name: Patricia Lyons Phone: (912)236-0363 Fax: (912)236-0363 Email: plyons@seniorcitizens-inc.org	3025 Bull Street, Savannah, GA 31405	HCBS - HCBS Services	Adult Day Care
		HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Port Wentworth Senior Citizens Center**

Contact	Address	Programs	Services
Name: Martha Weston Phone: (912)964-5411 Fax: (912)964-0509 Email:	100 Aberfeldy Street Port Wentworth, GA 31407	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Service Provider: **Senior Citizens, Inc. (Chatham County) [Parent]**

Contact	Address	Programs	Services
Name: Patricia Lyons Phone: (912)236-0363 Fax: (912)236-0363 Email: plyons@seniorcitizens-inc.org	3025 Bull Street, Savannah, GA 31405	HCBS - HCBS Services	Adult Day Care

Name: Patricia Lyons Phone: (912)236-0363 Fax: (912)236-0363 Email: plyons@seniorcitizens-inc.org	3025 Bull Street, Savannah, GA 31405	HCBS - Nutrition Services	Home Delivered Meals

Service Provider: **The Social Center/RBADC**

Contact	Address	Programs	Services
Name: Katie Horne Phone: (912)236-0363 Fax: (912)236-3030 Email:	64 Jasper Street Savannah, GA 31405	HCBS - HCBS Services	Adult Day Care

Service Provider: **Thunderbolt Senior Citizens Center**

Contact	Address	Programs	Services
Name: Linda Swanson Phone: (912)352-4846 Fax: Email:	3236 Russell Street Thunderbolt, GA 31404	HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Health Promotion/Disease Prevention Nutrition Education Senior Recreation

Parent Provider: **Senior Citizens, Inc. (Coastal Counties) [Parent]**

Contact	Address	Programs	Services
Name: Patti Lyons Phone: (912)236-0363 Fax: (912)236-3030 Email: BTW1939@bellsouth.net	3025 Bull Street Savannah, GA 31405	HCBS - Caregiver Services	Adult Day Care - Mobile
		HCBS - HCBS Services	Adult Day Care - Mobile
		HCBS - Nutrition Services	Home Delivered Meals
		HCBS - Senior Centers	Congregate Meals Exercise/Physical Fitness - Group Nutrition Education Senior Recreation

Service Provider: **Bryan County - Senior Citizens, Inc.**

Contact	Address	Programs	Services
Name: Patti Lyons Phone: (912)236-0360 Fax: (912)236-3030 Email: plyons@seniorcitizens-inc.org	PO Box 23858 Savannah, GA 31403	HCBS - Nutrition Services	Home Delivered Meals

Service Provider: **Liberty County - Senior Citizens, Inc.**

Contact	Address	Programs	Services

Name: Patti Lyons
Phone: (912)236-0363
Fax: (912)236-3030
Email: plyons@seniorcitizens-inc.org

P.O. Box 23858
Savannah, GA 31403

HCBS - Caregiver Services	Adult Day Care - Mobile
HCBS - HCBS Services	Adult Day Care - Mobile
HCBS - Nutrition Services	Home Delivered Meals
HCBS - Senior Centers	Congregate Meals
	Exercise/Physical Fitness - Group
	Nutrition Education
	Senior Recreation